THE CANADIAN NURSE

UME 54 • NUMBER 7
MONTHREAL

ERIODICALS R

Highlight for
JULY 1958

MACMILLAN AWARD ARTICLES

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JUL 23 '58
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OUR NEW PRESIDENT ALICE GIRARD

(See page 617)

(G. Carpenter)

THE CANADIAN NURSES' ASSOCIATION

Recent studies indicate actual milk allergy is not frequent. Belief is growing that infants are being too quickly deprived of milk, when the cause of allergy is not milk.

Even in the small percentage of milk allergies, a recent study* shows that more than ¾ of such infants react only to the whey protein. Only a few casein-sensitive babies do not tolerate evaporated milk, in which whey protein is made non-allergic by heat processing.

In the rare case when allergy is narrowed to milk, trial on evaporated milk often shows the baby reacts *only* to *unmodified* whey protein, need not be deprived of irreplaceable milk values.

*Ratner, Bret; Crawford, L. V.; and Flynn, J. G.: Amer. J. Dis. Child., 91:593, 1956

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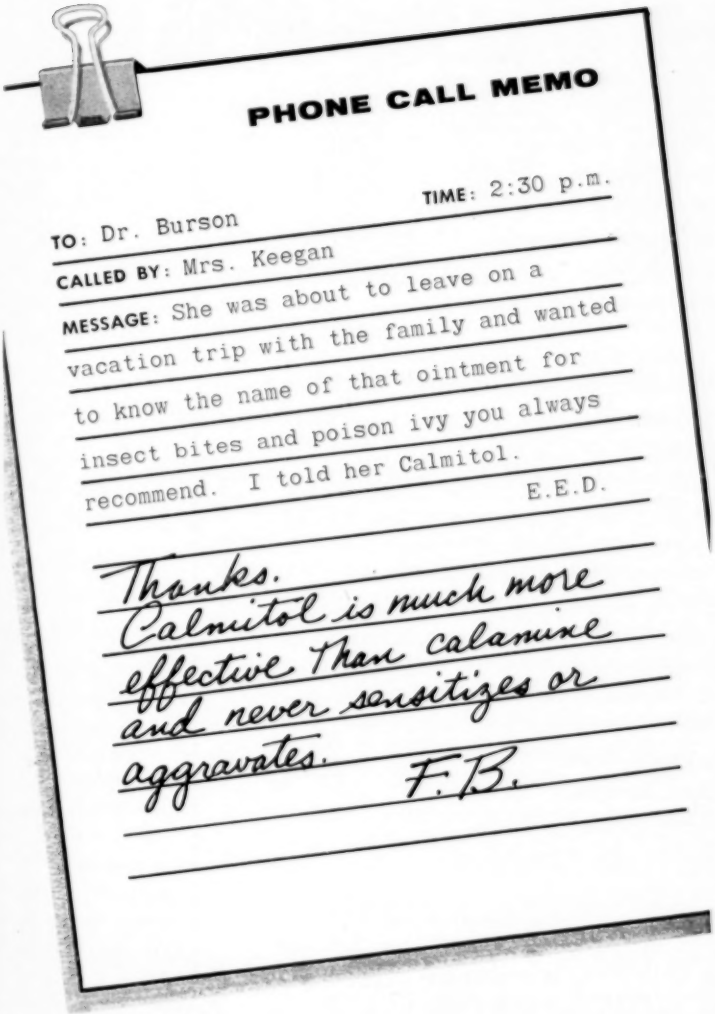
PHONE CALL MEMO
TO: Dr. Burson
TIME: 2:30 p.m.
CALLED BY: Mrs. Keegan
MESSAGE: She was about to leave on a vacation trip with the family and wanted to know the name of that ointment for insect bites and poison ivy you always recommend. I told her Calmitol.
E.E.D.
Thanks. Calmitol is much more effective than calamine and never sensitizes or aggravates.
F.B.

*Calmitol is the non-sensitizing antipruritic supplied as Ointment in 1½-oz. tubes and 1-lb. jars, and as Liquid, for more stubborn pruritus, in 2-oz. bottles by Thos. Leeming & Co., Inc., 286 St. Paul St., W., Montreal. *Write for samples.*

THE CANADIAN NURSE

L'Infirmière canadienne

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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Between Ourselves

THE TRIUMPHANT CELEBRATION of the 50th anniversary of the founding of the Canadian Nurses' Association is now a matter of history. Though hundreds upon hundreds of nurses swarmed the convention halls, as many thousands more were unable to be present. For the benefit of all those who were not there, the Journal story of what transpired will supplement your delegates' reports. Every effort will be made to have this complete running account of the day-by-day activities in the August issue.

This month we are most happy to present the keynote address that was delivered by **Daisy C. Bridges,** general secretary of the International Council of Nurses. Twenty-four years ago, Miss Bridges journeyed from England to Canada to attend the Silver Anniversary of our Association. At that time she little dreamed that she would return for the Golden Anniversary or that she would be occupying a position of such eminence in the nursing world.

Here, too, we want to give the membership at large a close-up glimpse of the gracious lady, whose photograph appears on our cover, our new president **Alice Girard.** The story of her personal background, her broad and varied professional preparation and her useful career appears on page 617.

* * *

All of the *Journal's* readers are familiar by now with the awards presented annually, by the Macmillan Company of Canada, for the best articles prepared by student nurses on topics that will portray comprehensive nursing care at its finest. Last year we published all of the prize-winning articles in the July issue. Many of you expressed your pleasure over this concentration of this interesting and worthwhile material in a single issue so we are using the same presentation technique this year. The articles are arranged in the order of rank assigned to them by the six judges who for 1958 were nurse supervisors or instructors from Saint John, Montreal, Ottawa, Winnipeg, Edmonton and Victoria.

Nursing instructors are reminded that the 1958 competition is in full swing. Many schools of nursing have never submitted any nursing care studies for the Macmillan Awards. Interest your students in competing for one of the prizes and, incidentally, having their article published in the *Journal.*

* * *

The National Student Nurses' Association in the United States with a total membership of over 75,000, has been one of the first associations to apply for membership in the International Student Nurses' Unit, according to the recent *Monthly News Letter* from I.C.N. Headquarters. Although many of the schools of nursing were represented at our convention this year, we have no national association for students in Canada. The chief deterrent probably is the fact that only half of the provincial nurses' associations currently have organized provincial student associations. It would be an historic event if, fifty years after our national association joined the I.C.N., a Canadian Student Nurses' Association might make application for international membership. What can be done about it?

* * *

Though very few of you make any remarks, encouraging or lambasting, regarding the material that is published in various issues, nevertheless, quite a number of you have enquired why we do not have a "Letters to the Editor" column. If you look over a page or two you will find "Random Comments" — quotations from some half dozen or so letters that subscribers have written us in the past four or five months. We cannot be sure when we will have enough letters to run this section again. That depends on *you.* Please don't just say "I like the Journal and read every bit of it." That is an encouraging remark, to be sure, but you would soon weary of reading it if we published it every time it is written to us. Be specific. What do you like? What articles do you disagree with?

Of course we could fake some letters. Believe it or not, some publications do that. So far your *Journal's* editorial staff has been too busy to concoct such fare for you. Do you want us to try it?

The people with the highest incomes today are mostly singers, TV personalities and movie actors. A sad commentary — because it proves that we are willing to pay more for amusement than we are for education, health and other really worthwhile subjects.

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As you know, babies like . . . and should have . . . variety in their foods. That's why Swift's prepare *14* varieties of Meats for Babies: 13 varieties of 100% meat, and Salmon Seafood. They also prepare Egg Yolks. All are carefully selected, cooked and strained smooth so they're delicious, nourishing and easy to digest.

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New Products

Edited by DEAN F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

ACNE-AID DETERGENT SOAP

Manufacturer—Stiefel Laboratories Inc., N.Y.; **Can. Dist.:** Winley-Morris Company, Limited, Montreal.

Description—A synergistic combination of pure, neutral, high molecular weight soap with a clinically-tested nonsensitizing sulphated oil detergent.

Indications—Designed for use in dermatoses characterized by pimples or pustules due to inflammation in the sebaceous glands such as acne.

Administration—Using warm water, massage lather on affected areas with fingers, cloth or facial brush as indicated. Rinse warm, then cold. Dry and apply medication, if any.

AGRIPPOL

Manufacturer—Herdt & Charton Inc., Montreal.

Description—Each tablet contains: Acetylsalicylic acid gr. 0.233, atropine aminoxide hydrochloride gr. 0.0005, phenacetin gr. 0.100.

Indications—Colds, coryza, grippe, bronchitis, hay fever, asthma, headache, neuralgia, respiratory disorders.

Administration—One tablet every 4 hours or 4 to 6 tablets during 24 hours.

ANAMID

Manufacturer—Mowatt & Moore Ltd., Montreal.

Description—Salicylamide tablets of 0.25 gm. and 0.5 gm.

Indications—For salicylate therapy in rheumatism, neuralgia, etc.

Administration—Two to 3 tablets daily with water, or as prescribed.

ANSOLYSEN

Manufacturer—Poulenc Limited, Montreal.

Description—Pentolinium tartrate (M & B 2050A) (pentamethylene-1:5 bis (1-methypyrolidium) hydrogen tartrate). New ganglion-blocking preparation presented in tablets and vials.

Indications—Hypertension. Possesses advantages over hexamethonium and merits consideration in the treatment of selected hypertensive patients. When given by mouth, it reduces blood pressure more readily without undue toxicity, and in smaller doses than do hexamethonium salts given orally. The duration of the hypotensive effect is more prolonged than with hexamethonium salts, and dosage adjustments are less frequently needed. There is less marked development of drug tolerance.

ANATENSIN

Manufacturer—The British Drug Houses (Canada) Limited, Toronto.

Description—A non-barbiturate daytime sedative and relaxant. Each capsule contains mephenesin (Myanesin) 0.25 gm. and Acetylcarbromal 0.25 gm.

Indications—Anxiety neurosis, chronic alcoholism, neuromuscular hypertension, anxiety associated with angina pectoris, neurogenic dermatitis, itching associated with anxiety states, as an adjunct to peptic ulcer therapy and for the alleviation of stress of psychogenic origin.

Administration—Orally. One capsule 2 to 4 times a day. If necessary this can be increased to 2 capsules.

BRADOSOL POWDER

Manufacturer—Ciba Co. Ltd., 1235 McGill College Ave., Montreal.

Description—A quaternary ammonium compound, used to prepare solutions with powerful antiseptic, germicidal, deodorant and detergent qualities against a wide range of organisms (including staphylococci) yet it does not injure the skin, mucous membranes, fabrics or metals.

Indications—As an antiseptic with which to minimize staphylococcal contamination associated with boils; also general purpose antiseptic and disinfectant for surgical and medical use.

Administration—Most frequently used in 0.1% solution (1 gm. to 1 quart tap water) but solutions of 0.01% (1 gm. to 2 gallons tap water) are adequate for many purposes. Full instructions for use are available upon request.

SOYBORO POWDER PACKETS

Manufacturer—Dome Chemicals Inc.; **Can. Dist.:** Professional Sales Corporation, Montreal.

Description—Aluminum sulphate, calcium acetate, boric acid, soyaloid (colloidal soybean complex). Contents of packet in 1 pint of water provides 1:20 Burow's solution equivalent plus soyaloid.

Indications—Eczemas, dermatitis, abscesses, trauma.

Use—Add one packet to 8 or 16 oz. of water, stir to form colloidal solution. Use hot or cold as a wet dressing, soak or therapeutic bath.

NOVA SCOTIA SANATORIUM
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for
REGISTERED NURSES

THE NOVA SCOTIA HOSPITAL offers to qualified Registered Nurses a six-month certificate course in *Psychiatric Nursing*.

- Classes in March and September.
- Remuneration.
- Preference given to Nova Scotia applicants.

For further information apply to:

Superintendent of Nurses
Nova Scotia Hospital
Drawer 350
Dartmouth, Nova Scotia

COMBID

Manufacturer—Smith Kline & French Laboratories, Montreal.
Description—Each spansule capsule contains: Darbid (isopropamide) 5 mg., prochlorperazine 10 mg. in sustained release form. Provides long-acting anticholinergic-tranquilizer effects.
Indications—To control both the physical and psychic components of peptic ulcer and other gastrointestinal disorders associated with hypersecretion or hypermotility.
Administration—Suggested dose — one capsule every 12 hours.

FALAPEN-S

Manufacturer—Charles E. Frosst & Co., Montreal.
Description—Tablets: Potassium penicillin-G 125,000 units; sulfamethazine 167 mg., sulfadiazine 167 mg., sulfamerazine 167 mg. (a total of 7½ gr.)
Indications—Infections which are sensitive to penicillin, sulfonamides or their combinations.
Administration—Four tablets initially, followed by 2 tablets every 8 hours, preferably before meals, or as prescribed.

K-PREDNE-DOME

Manufacturer—Dome Chemicals Inc.; **Can. Dist.:** Professional Sales Corporation, Montreal.
Description—Tablets: Prednisolone 1 mg. or 5 mg., potassium chloride gr. 3.
Indications—For anti-inflammatory action in rheumatoid arthritis, asthma, hay fever, with protection against potassium depletion.
Administration—Initially, 20 to 30 mg. daily until good response obtained. If no response in 7 days, diagnosis should be reconsidered. With favorable response determine maintenance dose by reducing dosage by 1.0 mg. every 2 or 3 days. Should be in 5 to 20 mg. range.

LIQUAEMIN SODIUM DISPOSABLE SYRINGE

Manufacturer—Organon Inc., **Canadian Branch**, 286 St. Paul St. W., Montreal.
Description—Sterile aqueous solution containing in each 1 cc. disposable syringe 20,000 U.S.P. units (approx. 200 mg.) of highly purified sodium heparin.
Indications—In the prevention and treatment of coronary thrombosis, thrombophlebitis and thrombosis of the central retinal vein; also in frostbite, vascular surgery, blood transfusion, and routine hematological tests.
Administration—Average dose is 20,000 U.S.P. units every 12 to 14 hours, depending upon the patient's response as determined by the clotting time.

McMASTER UNIVERSITY
School of Nursing
1957-1958

I DEGREE COURSE IN BASIC NURSING (B.Sc.N.)

A Four-Calendar-Year Course designed to prepare students for all branches of community and hospital nursing practice and leading to the degree, Bachelor of Science in Nursing (B.Sc.N.). It includes studies in the humanities, basic sciences and nursing. Bursaries, loans and scholarships are available.

II DEGREE COURSE IN SCIENCE TEACHING FOR GRADUATE NURSES (B.Ed.N.)

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For additional information, write to:

School of Nursing,
McMaster University, Hamilton, Ontario.

Random Comments

You may be interested to know that the article by Charles V. Willie, "Love for the Helping Professions," (Jan. '58) was brought to the attention of the staff nurses by one of your nurses now employed at the University of Texas Medical Branch. I was fortunate in being present at the time and most impressed by the initiative of this nurse to share information with her colleagues. It would please me to have a copy of that issue.

E. C. G., Texas

* * *

I do enjoy reading the Journal and am happy to report it well received among our student nurses in whom we endeavor to develop the habit of reading professional nursing literature.

H. C., Washington, D.C.

* * *

One is very proud of our Canadian nurses who are so seriously looking into the future of nursing. These are times of change and you have published articles which have been most helpful to the "average" nurse in keeping herself informed.

During the past year, my work has brought me in contact with a hospital where several of the staff, even a supervisor, were not registered nurses. It did not seem right that those with such limited training should be in charge of wards or doing nursing work for which they had received no instruction. My first reaction was that these people must somehow be restricted in their sphere of influence. But the shortage of qualified registered nurses inevitably has meant that this partially trained help is more desirable than no help at all.

After reading the addresses given at the Canadian Conference on Nursing and other

UNIVERSITY OF BRITISH COLUMBIA

COURSES FOR GRADUATE NURSES

1. ***Leading to the Degree of Bachelor of Science in Nursing (B.S.N.):***
   An integrated program which includes preparation for staff positions in public health nursing as well as the fundamentals of teaching, supervision and administration and their application to clinical nursing. Students are required to select one advanced clinical nursing course—i.e., Medical-Surgical, Obstetric, Pediatric, or Psychiatric Nursing.

   Students with an appropriate Senior Matriculation can complete the Course in approximately two years. Those with Junior Matriculation require approximately three years.
2. ***Leading to a Diploma in Public Health Nursing:***
   A ten-month course which prepares for staff positions in public health nursing.
3. ***Leading to a Diploma in Clinical Teaching and Supervision:***
   A ten-month course which prepares for hospital positions that entail teaching, supervisory and administrative activities. Students are required to select one of the advanced clinical nursing courses listed above.

N.B.: The School of Nursing also offers, for high school graduates with University Entrance, a *Basic Professional Course* leading to the degree of B.S.N.

For further information write to the

DIRECTOR, SCHOOL OF NURSING, UNIVERSITY OF BRITISH COLUMBIA, VANCOUVER 8, BRITISH COLUMBIA.

articles in *The Canadian Nurse* I think I have come to a more or less satisfactory and objective answer.

A similar situation exists between the scientist and the technician. In all straight technological situations, when the customer knows what he wants, he goes to the technician. But if he doesn't know what he wants, then he goes to the professional person for help. The technician knows the "how" and can perform stated, straightforward tasks; the professional seeks the "why" and prescribes the tasks.

Thus it seems to me the practical nurse is concerned with the "how" of nursing — the technique. But it is the professional nurse who prescribes which technique should be used. Though most of the bedside nursing may be done by practical nurses, I am beginning to see just how much the professional nurse is required.

E. M. W., Ontario

* * *

It has been my intention to write you how very much I enjoy *The Canadian Nurse*. For a few weeks every year I am active in nursing and I find the *Journal* helps to fill the gap between me and my profession.

I especially like the New Products section. This is a wonderful way for nurses to become familiar with new drugs. The advertising pages are also useful as they familiarize me with new things.

(Mrs.) A. I. M. C. New Brunswick

* * *

Congratulations to the author of Simplified Parliamentary Procedure. I approve every word. It has been getting worse at meetings because no emphasis is being put on the "motions proposed."

Sr. S. R., Ontario

* * *

Your excellent articles on parliamentary practice have come at just the right time.

M.D., Illinois

* * *

I am very much interested in your series on parliamentary procedure. Something unusual came up in one of our meetings not long ago. A motion was moved, seconded, passed and recorded in the minutes. Several days later, the member who had made the motion telephoned and said she was sorry she had made the motion and asked that it be stricken from the minutes. Is this permissible or must the motion be read as recorded at the next monthly meeting?

Editor's Note: Having been passed, the motion would have to stand until rescinded.

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   Classes following the six month course in Obstetrical Nursing.

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2. Six month course in Operating Room Technique and Management.

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Complete maintenance or living-out allowance is provided for the full course.

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For information apply to:

Director
School of Nursing Education
University of Manitoba
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School of Nursing

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For further information please write to:

DIRECTOR OF NURSING
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Gross Salary: $85 for 1st 2 months.
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THE NATIONAL HOSPITAL
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London, W.C.1

and

MAIDA VALE HOSPITAL
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Director of Nursing,
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A two-year program designed to prepare the nurse for positions in Nursing Education and Public Health Nursing. The program includes courses in the humanities, basic sciences, supervision, teaching and public health nursing.

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IV. **Diploma Course in Teaching and Supervision in Schools of Nursing**

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For information write to:

Director, School of Nursing
The Johns Hopkins Hospital
Baltimore 5, Maryland, U.S.A.

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FOR
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In various clinical fields, beginning September 15, December 15, 1958, March 9, and June 1, 1959.

Room, meals, and laundering of uniforms provided.

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DIRECTOR,
COOK COUNTY SCHOOL
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DEPT. C., 1900 WEST POLK ST.,
CHICAGO 12, ILLINOIS

SCHOOL for GRADUATE NURSES
McGILL UNIVERSITY

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Two-year program for nurses with McGill Senior Matriculation or its equivalent. Three-year program for nurses with McGill Junior Matriculation or its equivalent. In the first year students may specialize in Public Health Nursing, Teaching of the Basic Sciences, or in Teaching and Supervision in one of the following clinical fields: Medical-Surgical Nursing, Psychiatric Nursing, Maternal and Child Health Nursing.

In the second year students elect to study in one of the following fields: Nursing Education, Administration in Hospitals and Schools of Nursing, Administration in Public Health Nursing.

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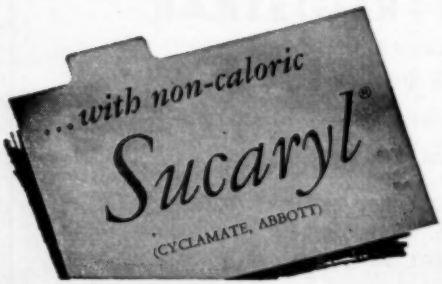

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About that Readership Survey

FOURTEEN YEARS AGO THIS MONTH, a new editor's name appeared on the title page for the first time. Now, 168 issues later, it seems worth while to look back over those years and, in the light of the Readership Survey conducted by the Committee on Public Relations, to assess the growth, the value and the influence of *The Canadian Nurse*. Providing care for those who are ill might be regarded as a fairly routine matter. Yet nursing is probably one of the least static of all the professions. How efficiently is the *Journal* pointing the way to new developments, to the new demands made upon nurses? How active is it in shaping opinions, in providing leadership?

Let us look first at some of the numerical changes. In 1944, the Canadian Nurses' Association had a total membership of 21,431; *The Canadian Nurse* had 4916 paid subscribers in Canada or 22.9 per cent. Today, the CNA membership is very close to the 50,000 mark, quite refuting any claim that the "shortage" of nurses is more acute. The total number of paid subscribers has skyrocketed to over 40,000. Actual figures for June, 1958 will be given later. Moreover, the Readership Survey (R.S., henceforth) revealed that 31.1 per cent of the subscribers pass their copies along to others to read, the average number of such "others" being estimated at three. Thus, the reading audience per issue may be as large as 65,000 persons — a mighty throng of professional people interested primarily in the well being of others. Equally valid as an indicator of the values these readers find in their *Journal* is the R.S. finding that 86.2 per cent of those who do not pass along their issues keep them on hand for future reference purposes — a definite tribute to the calibre of the material the nurses of Canada have contributed as articles.

What about the editorial content? What kind of material is most useful, most desired, by these thousands of readers? Before considering the R.S. findings let us note the very wide variety of possible reader interest that must be met in *every* issue:

1. There are the nurses in the adminis-

trative and supervisory group either in hospitals or the public health field; those whose chief concern is nursing education. They constitute possibly 10 per cent of the total.

2. There is the very large body of nurses in staff positions or engaged in private nursing. Office nurses fit into this group, too. These are the backbone of our profession, forming probably 65 to 70 per cent of the membership.

3. Also on the staff level but differing in their needs from those who care for the sick are the ever-growing numbers of nurses working in the preventive field — the public health nurses, including those engaged in occupational health work and the nurses in military service. Place their numbers at 15 to 20 per cent.

4. To thousands of youngsters in our schools of nursing the *Journal* is a constant source of information. Taught early in their training to use the index, student nurses in all parts of Canada are among the most avid readers of *The Canadian Nurse*.

5. This is an unmeasurable group — the large numbers of former nurses whose duties as wives and mothers prevent them from taking much if any part in current nursing activities; the middle-aged nurses whose home duties have gradually diminished as the family grows up; the older nurses who have retired from the positions they formerly filled so capably. Each has a need to know what is going on in the current nursing scene if for no other reason than to talk intelligently about it with their neighbors.

These are the potential readers. What they expect from their professional journal is as diversified and individual as it is definite. In order of preference, here is what the R.S. found out about reading matter appeal:

16.3% Technical articles on nursing and medical subjects
15.3% New types of equipment and pharmaceutical products
13.4% Comprehensive nursing care
13.2% Controversial articles
13.0% Articles about nursing administration and education
11.7% Research studies
9.9% Current news of nursing personalities and events
7.2% News of CNA and provincial associations

You will understand why we seldom have a "Random Comments" column when you realize the R.S. found that only 1.5 per cent of the nurses in Canada ever write letters to the editor commenting on articles in the *Journal*. An accumulation of letters received over the past several months appears elsewhere in this issue.

Many other aspects of the *Journal* were revealed by the Survey. A somewhat unexpected one was the readership and usefulness of the Employment Opportunities section. Grown from two pages in 1944 to an average of 18 in 1958, 85.2 per cent of the nurses questioned indicated that they read through these advertisements regularly, 26.3 per cent have used this section to secure new positions.

Equally gratifying from the point of view of those staunch supporters of your *Journal*, the many advertisers, 61.5 per cent of the commercial advertisements included in the R.S. were noted, read in whole or in part by over 50 per cent of the nurses questioned, some running as high as 80 per cent. In no instance did reader interest drop below 35.5 per cent.

The editorial staff of your *Journal* is being expanded with the aim of bringing all of the readers in every category a better and stronger ladder to new heights in their professional work and growth. That is our pledge for the next fourteen years!

MARGARET E. KERR
Editor

The basic faith which underlies the democratic form of government can be summed up in the statement that when power resides in the people, the people are wise enough to decide for themselves what policies are both expedient and right. This conviction can be justified only by results obtained from the direct and general participation of the people in the activities of government. But that participation must be based on informed goodwill. Unless the people of the democracies understand their problems they cannot expect to make the system work. In national as in personal affairs ignorance and indifference are an invitation to disaster. In these days neither is excusable; each is a political sin.

—HUGH L. KEENLEYSIDE

Madame la Présidente

IT IS ALWAYS EXCITING to do something for the first time. To be the focus of that "first" is an even more exciting experience. This is the first time that a nurse of French-Canadian origin has been acclaimed to preside over the affairs of the Canadian Nurses' Association. Alice Girard, whose photograph appears on the cover, is our gracious and capable president.

Born in Waterbury, Connecticut, on a November day, Alice was the seventh daughter, the youngest in a family of eleven children. Many years separated her from her brothers and sisters, some of whom were married before she was born. Thus, her early childhood recollections are those of a lonely child living with her elderly parents.

Formal education began in an English language environment in Waterbury. To ensure fluency in her ancestral language as well, the rule was made that only French should be spoken within the home. This parental planning has produced a woman who is equally at home in both languages in her thinking, her reading, her talking.

Father's retirement brought them back to Canada when Alice was eleven. She continued her education at St. Joseph's convent, St. Hyacinthe, Quebec. Already a voracious reader, she would smuggle books to bed and read by flashlight far into the night. Like many bright youngsters, she decided at that time she would make a career of writing.

Following graduation from high school, Miss Girard began teaching school in a convent in Maine. She loved it! Then one of her friends, who had started upon her nurse's training, came home for her first vacation. As many young nurses will do, she talked so enthusiastically of the "fascinating world of nursing," Alice became interested to explore the intellectual side of this new profession. She did not intend to nurse — she would go back to her beloved teaching after the three years of training were concluded! So she graduated from St. Vincent de Paul Hospital, Sherbrooke, Que., in 1931. Her new profession has become her life-long career!

Those were depression years when jobs were scarce. After a brief try at bedside nursing with Metropolitan Life Insurance Company, Miss Girard became a general practitioner's assistant in a large rural area in the Eastern Townships of Quebec. The next five years proved to be the "most valuable experience" of her life as she assisted with home deliveries and minor surgery, out in all kinds of weather, day or night, driving a horse and buggy over good roads, bad roads — no roads at all — to bring succor to the needy.

More learning became her greatest ambition. How could people in the homes be taught more efficiently to care for those who are ill? The answer seemed to be a course in public health nursing so Miss Girard enrolled in the School of Nursing, University of Toronto.

Many nurses have studied at one university; quite a few have attended two; a small number are alumnae of three. Driven by an insatiable urge for more and more knowledge, Miss Girard received her Bachelor of Science from Catholic University of America, Washington, D.C., her Master of Arts in public health nursing from Columbia University, New York. In 1954 she took all the available credits and served her internship in hospital administration at Johns Hopkins University, Baltimore.

The opportunity to teach was restored to Miss Girard when, in 1942, she was appointed director of the School of Public Health Nursing of the University of Montreal. Five years later she relinquished the directorship, though continuing as a lecturer, when she became the superintendent for Canada of the nursing service of the Metropolitan Life Insurance Company. She accepted her present position as director of nursing at Hôpital St. Luc, Montreal, in 1955.

That is Alice Girard the nurse. What of Alice Girard the woman? As would be expected, she still reads far into the night, every night. English or French, she probes every book that comes into her hands. She has provided the means for herself to "get away from it all" by buying a home within easy driving distance of Montreal. There, over weekends, she lovingly tends her flower garden, clips the hedge, mows the lawn. To build a new structure, do odd repair jobs, apply a coat of paint, is the joy of her life. Indoors, somebody else can do the cooking!

Miss Girard's newest hobby is color photography. She thoroughly enjoys her car and looks forward to the day when she will own a cabin cruiser on the Richelieu River

that laps her lawn. An exceedingly active, alert, well informed woman, she is entering upon her new duties with all of the enthusiasm for which she is famous. Her proven qualities of leadership bode well for the future of the Canadian Nurses' Association.

Madam President, we the nurses of Canada salute you and wish you success in all of your new endeavors.

In Memoriam

Marie (McGillis) Brewster who graduated from St. Michael's Hospital, Toronto in 1928, died on February 24, 1958.

* * *

Mary Ann (Willis) Brodie, a graduate of the Kingston General Hospital in 1924, died on January 12, 1958.

* * *

Anne (Oliver) Cardick who graduated from the Ontario Hospital, London in 1931, died recently.

* * *

Barbara Cummings, a graduate of the Queen Elizabeth Hospital, Montreal in 1953, died on October 28, 1957. Following graduation she was on the staff of the outpatient department for a time before going to Winnipeg. Miss Cummings was a past president of the Q.E.H. alumnae association.

* * *

Victoria Augusta Golding who graduated from Victoria Hospital, London in 1900 died on April 12, 1958. She was 83 years of age.

* * *

Pauline L. G. Holdway a graduate of St. John's Hospital, Toronto in 1925 died recently. Most of her professional life had been devoted to private nursing.

* * *

Kathleen Z. Keegan, a graduate of Aberdeen Hospital, New Glasgow, N.S. in 1942, died recently. She had engaged in institutional nursing.

* * *

Clair (Kelly) Labine who graduated from St. Michael's Hospital, Toronto in 1922 died on March 4, 1958.

* * *

Gerlena (Whiten) Lang who graduated in 1931 from the Public and District Hospital, Smiths Falls, Ont., died on February 23, 1958.

* * *

Mabel Gertrude Lunny who practised her profession for many years in New York, died in Montreal during April, 1958.

* * *

Margaret C. McCabe a graduate of the Memorial Hospital, Peterborough, England in 1944 died in Toronto on May 4, 1958. She had been engaged in private nursing.

* * *

Jean (Rowan) McClintock a graduate of the General and Marine Hospital, Owen Sound, Ont. in 1904, died on April 7, 1958. Mrs. McClintock was one of the pioneer nurses of the district. She was 90 years old.

* * *

C. Laeta McKinnon who graduated from the Toronto General Hospital in 1927 died on December 16, 1957. She had engaged for a number of years in institutional nursing.

* * *

Margaret (Sutherland) Phillips a graduate of the Toronto General Hospital in 1901 died recently in Saskatoon after a long illness. She had held the position of nurse in charge of the Students' Clinic, University of Saskatchewan for 19 years. In 1944 she became registrar for the Saskatoon chapter of the SRNA and continued with this work until illness forced her retirement in 1956.

* * *

Lucy Virginia (Budrow) Rodger who graduated from Highland View Hospital, Amherst, N.S. in 1938 died on April 26, 1958.

* * *

Ellen E. (Slack) Slack, a graduate of St. Luke's General Hospital, Ottawa died on April 14, 1958. During the early years of World War II Mrs. Slack had operated a hospital for evacuees at Hayward's Heath, Sussex, England.

* * *

Winnifred (Rame) Whalen who graduated from St. Michael's Hospital, Toronto in 1913 died on March 17, 1958. Her professional life was spent in private nursing.

* * *

Noreen (Lane) Wilson a graduate of the Royal Victoria Hospital, Montreal in 1944, died on April 23, 1958.

* * *

Shirley May Wright who graduated from the General Hospital, Saint John, N.B. in 1955 died in a car accident on May 18, 1958.

(Continued on page 623)

The Patient, The Present, and Progress

DAISY C. BRIDGES, R.R.C.

TWENTY-FOUR YEARS AGO there happened two very important events in my life. The first was that I became the proud possessor of a most ravishing new, blue satin long evening frock. The second, and the occasion for which I needed the frock, was my attendance at the 25th Anniversary Convention of the Canadian Nurses' Association. I was a night supervisor at the time and one day at about mid-day, when I had been in bed and asleep for an hour or so, I was suddenly awakened and summoned to the Nursing School office.

At that time it was Miss Lloyd Still, the President of the International Council of Nurses, who directed both the Nightingale School and the Nursing Service of St. Thomas's Hospital. When I arrived in her office she told me that she was sending me to Canada. She had been invited as a representative to your 25th Anniversary Convention and could not go herself. I said, very naturally, "But why are you sending *me*?" Her reply was, "Well, you will probably have to speak, and you have a loud voice that carries." That, I think, was my only qualification!

Today when I think about that convention, I still remember very clearly how proud I felt of the blue frock, and how happy I was at being among you. But whether it was the blue frock or the convention, I can truly say I have never been quite the same person since. When I arrived back in London, Miss Lloyd Still said I would never settle down again. That was not quite true, for I returned to night duty and remained on the hospital staff for several years; and except for the war years when the Army sent me to several countries overseas, it was actually fifteen years later that I became actively concerned in international nursing affairs.

And yet your 25th Anniversary Convention did something to me. I learned how much professional organization meant to Canadian nurses — the importance of their membership in the Canadian Nurses' Association and in the International Council of Nurses, and therefore professional organization began to mean more to me also. I met not only many Canadian nurses who have become my life-long friends, but also nurses from several other countries who were attending your convention. I believe as a result I learned to be less insular and to be more interested in your affairs and theirs. The result was a changed outlook and attitude of mind.

And so, first of all, I want to tell you how glad I am to be here and to give you my heartfelt good wishes, not only for your 50th Anniversary Celebrations but for the years ahead. I sincerely hope that my voice still carries far enough to express to you all my gratitude and appreciation for what I owe to you — your generous hospitality and your inspiring leadership.

Now I must try to explain my title.

(Madame Yevonde, Knightsbridge)
DAISY C. BRIDGES

Miss Bridges is the General Secretary of the International Council of Nurses.

Apart from the fact that I am always somewhat prone to the use of alliteration, these words, I believe, have some meaning for all of us. By "The Patient," I mean *Everyman* — all for whom we are called on to provide care in the widest meaning of the word: care in sickness, care in health, care during the most difficult and tedious period of recovery and rehabilitation; care not only in the hospital and the clinic but in the school, the factory and the homes of the people.

That great American nurse, Annie Goodrich, outlined in such a pertinent way the extent of our responsibility when she said, "As nurses, we influence people before they draw their first breath, and not until they draw their last breath do we release them from our influence."

"The Present" — well, I think of it as that period of our lives during which we are seldom satisfied. I believe it is one of the inconsistencies of human beings that we older ones are apt to look backwards with regret, and the younger we are the more we tend to look forward in anticipation of something better than we have at present. There can be, however, in all our lives such a thing as a mirage. The traveller in the desert looks ahead and sees water. He hurries forward and may find sand where he had seen a lake. He looks back and sees a lake where, when he was there he was toiling through sand.

This observation is not meant to depress you, or to underrate the importance of the Theme you have chosen for this convention, but as we move from the present into the future, and as we prepare ourselves for it, we may perhaps take guidance from some words of our Queen in her Christmas broadcast:

> Because of the changes which have taken place many people feel lost and unable to decide what to hold on to and what to discard, how to take advantage of the new life without losing the best of the old. But it is not the new inventions which are the difficulty; the trouble is caused by unthinking people who carelessly throw away ageless ideals as if they were old and outworn machinery.

Finally, there is in my title the word "Progress," and all I need do in defining the importance of that word is to quote to you some words of Florence Nightingale — as true for us now as when she spoke them some 100 years ago.

> For us who nurse, our nursing is a thing which, unless in it we are making progress every year, every month, every week, take my word for it we are *going back*. A woman who thinks in herself "Now I have learned all there is to be learned," she is *gone back* already."

How tremendous have been the changes in the world since your 25th Anniversary Celebrations — progress in medicine and surgery, anesthetics and antibiotics, developments in nursing and nursing education to keep us in line with this progress in science and scientific discoveries, changes too in methods of transport and of communication. It took me quite a long time to travel here in 1934. Two years ago I went around the world and visited five countries in 40 days between Easter and Whitsuntide. One can fly to the other side of the world and find that one's deeds, and, alas, one's misdeeds also, are known there almost before one has perpetrated them. So in these 24 years the world has grown smaller, and seems to be closing in on us.

The important thing for us, is to learn how to adapt ourselves to these new exciting and sometimes rather frightening conditions, in fact to learn how to live internationally. Why do I think that this is so important for us as nurses? In the first place because we are members of the oldest international association for professional women, and can therefore set an example of good professional organization. I shall leave it to our President, Miss Agnes Ohlson, to talk to you about our international responsibilities and commitments, but I would remind you at this point that for half a century the nurses of the world have built up a fine spirit of international cooperation. It is a priceless heritage. In a world of chaos it is our contribution, as nurses, to no less a cause than the cause of world peace. We must hand on this spirit of cooperation in every way we can to succeeding generations.

The second reason why it has seemed to me that perhaps we all need

to know more of international affairs is that we are all very busy people, and extreme busyness can sometimes tend towards extreme insularity. I would like to repeat to you a conversation overheard recently in a London bus — although I doubt whether such a conversation would have occurred anywhere but in England. It went like this:

Conductress: I haven't seen you for a long time.

Chinese Gentleman: I've been away.

Conductress: Somewhere nice I hope?

Chinese Gentleman: Yes, very nice — China.

Conductress: Oh, was the weather good?

Chinese Gentleman: Yes, very good.

Conductress: *Well, that's the main thing isn't it?*

Of course you all know that in England everyone is more weather conscious than in any other country, and that at all times of the year it is the main topic of conversation, but the sad thing is I am afraid some of us are not unlike that conductress. Does the weather matter more to us than the fact that there are 600 million people in China, and we do not really know what is the extent of their social services — who looks after them in health and sickness and in old age.

Many countries that I visit are grumbling that they have a shortage of nurses, yet some have one nurse to 300 of the population, while in others there may be one to 100,000; indeed, there are some countries where there are almost no nurses at all. Are we interested in the fact that the world's population is increasing at the rate of 5,000 per hour, 120,000 per day and 43 million per year? That is an increase that will double the world's population by the end of the century. And connected with this rise in the population, do we think more of our own physical needs than of the fact that even now one-third of the world's population exists at the starvation level, and of the remainder, many thousands of people are always underfed?

We speak, perhaps with pride, of the fact that our tuberculosis rate is steadily decreasing; indeed, there are some countries in which tuberculosis has been practically eliminated. Do we ever pause to wonder how it is in other countries? I could tell you of one country which I visited a few years ago, and where at that time one person per minute was dying of tuberculosis. Are we worried that in many countries — and maybe it is true of this country also — mentally ill patients occupy between 40 and 50 per cent of the hospital beds? Have we been aware of the fact that up until ten years ago three million people died each year of malaria, and although with the new drugs the death rate has been cut by 30 per cent, nevertheless three-quarters of the world's population still live in malaria zones, and this is therefore still an international problem.

Finally, and perhaps most important of all, does it worry us that millions of people, through no fault of their own, are refugees from their own countries, with very little hope of return, and that two million are still eating their hearts out in refugee camps? Towards the end of the last war when country after country was being occupied and suppressed, and the inhabitants subjected to every kind of indignity, it was the Archbishop of Canterbury who said he doubted if there had been so much unhappiness in the world since the twelfth century. But can we truly say it is a happier place now, and if not, what can we, as nurses, be doing about it now or for the future?

We do not have to cross the Atlantic or to travel anywhere in order to learn to live internationally. All we need is a realization that in our profession we have no barriers of race, or creed, or caste, or color, or nationality, and that as nurses we are citizens not of one country only but of the world. Learning to live internationally means an attitude of mind rather than any action we need necessarily to take, and in this Canada has much to teach us. Wisely and patiently you have achieved a unity with two races and two languages, and to maintain that unity you have risen above the controversies of politics. It has been said that what the world needs most is an acceptance of world responsibility as world citizens, and that those of us who are secure and comfortable and not hungry should be willing to spend

an appreciable amount of our time worrying about, or at least being interested in, those who are less fortunate.

And so, as we advance into the second half of this great century, there are perhaps a number of factors which will affect the future, even our own future as a profession, and which we should be keeping in mind. We live in an age of scientific advances — new drugs, new vaccines, improved insecticides, better methods of combatting disease, a freer exchange between countries of scientific information and practical experience. But this advance in knowledge and methods of treatment does not solve all health problems. As the control of infectious disease advances, other problems take on new importance. More people survive into older age groups; our environment is becoming more complex; greater speeds in the air and on the roads create new hazards and new stresses, while new sources of energy are being developed which we hardly know how to control.

All these achievements are of no service at all to humanity unless they make human life richer and fuller. It is therefore essential that in this rush of progress man must learn to live with man. The strain of doing so seems sometimes to defy even governments. Perhaps as nurses we can help to show them the way. I am reminded of an absent-minded English bishop who was travelling by train somewhere in his diocese to give an address or preach a sermon. On his way he lost his ticket, but he was well known to the officials on the train so they hastened to reassure him. "It is quite all right, my Lord, we all know you and we are quite prepared to take you without your ticket." To which the somewhat irate bishop replied, "It may be all right for you, but what about me? *I don't know where I'm going.*"

It is essential that we, as individuals, should know where we are going, and in what direction, as a profession, we are travelling. I guess that this necessity is behind your choice of a theme for this week. May it not be that the ticket which *we* must not lose is the realization that in spite of the technical advances and scientific discoveries, perhaps even because of them, our patients, who are still human, are needing our sympathy, our understanding and our compassion almost more than ever before. Nursing as a profession which has set itself the highest standards, is already equipped to change with the times and to meet the challenges and opportunities of a new age. But whenever this new age is born we, as nurses, must be concerned, as we always have been, with the defence of spiritual values — with faith, and loyalty, and integrity, and self-sacrifice.

I do not need to remind you that as a profession we have a great history and great traditions. With the knowledge that there is still a great work for us to do, let us be as confident in the future as we are justly proud of the past. I have recently read — and I am happy to have the opportunity of passing it on to you — that the future of Canada defies the imagination of man. You have a land of expanding industries and of vast untouched mineral resources. The whole country is pulsating with life, but the writer I am quoting continues:

> Resources in themselves are not sufficient to bring prosperity; the human element is still the dominating one. Confidence in the future rests on two major solid foundations. One, we have to admit is wealth; the other is the character and quality of the people. We can be thankful, that it is to such a people there is presented so great an opportunity.

To this I would only add that what is true of a whole people can surely be true, also, of a profession, and that future greatness and future progress is determined by the quality of the individual.

The Patient, the Present, and Progress — and may I be forgiven if I indulge my passion for alliteration and refer you for one moment to the Past! Sir Winston Churchill in the last volume of his monumental history, has described the nineteenth century as a period of purposeful, progressive, enlightened and tolerant civilization. Can the same be said of the twentieth century, and is not this, in fact, the kind of civilization we still need to foster as we pass from the present into the unknown future?

To work in the field of health means

disregarding the narrow limits of national boundaries, for health is something that all nations desire. Every nation, by promoting its own health and sharing its discoveries, adds to the better health of other nations. As nurses, and with our great international heritage, we too can work towards this ultimate ideal and at the same time contribute towards the fulfilment of a prophecy of that great reformer, Arnold Toynbee, who said: "The twentieth century will be chiefly remembered, not as an age of political conflicts or of technical inventions, but as an age in which human society dared to think of the welfare of the whole human race as a practical objective."

Wondrous and very sweet is our name. Canada! The very word is like a boy's shout in the springtime, is like the clamor of geese going north and the roar of melting rivers and the murmur of early winds.

Can we not hear the sound of Canada? Can we not hear it in the rustle of yellow poplar leaves in October, and in the sudden trout-splash of a silent lake, the whisper of saws in the deep woods, the church bells along the river, the whistle of trains in the narrow passes of the mountains, the gurgle of irrigation ditches in the hot nights, the rustle of ripe grain under the wind and the bite of steel runners in the snow?

Have we not felt the texture and living stuff of Canada? Have we not felt it in the damp, springy forest floor, in the caress of the new grass upon our face, in the salt spray off Fundy or Juan de Fuca, in the hot sun of the prairies, in the beat of blizzards and the fierce surge of summer?

And the colors of Canada, those also have we seen. We have seen them in the harsh sweep of prairie snow, in sunlight and shadow vibrant across the heavy-headed wheat, in foaming apple orchards and in maple woods, crimson as blood, and in bleeding sumac by the roadside, and in white sails of schooners out of Lunenburg and in the wrinkled blue face of mountains. And we have smelled the clean, manly smell of Canada, in pine forest and settlers' clearing fires, and alkali lakes and autumn stubble and new sawdust and old stone.

Yes, but we have not grasped it yet, the full substance of it in our hands, not glimpsed its size and shape. We have not yet felt the full pulse of its heart, the flex of its muscles, the pattern of its mind. For we are young and full of doubt, and we have listened too long to timid men. But now our time is come and we are ready.

—Bruce Hutchison

Conservative estimates place the numbers of children with reading defects as high as 10 to 15 per cent of our school population. Of this formidable number about 1-2% of pupils are non-readers. A child who is a non-reader cannot read anything. English letters may as well be Egyptian hieroglyphics since they are just meaningless symbols. — *Health*

* * *

A health education poster showing a toothbrush dangling on a string in front of a shark with white shiny teeth was used in New Zealand to promote dental hygiene. It was sent to one of the South Sea Island groups for the same purpose. The only result was that the local people immediately asked what the new kind of bait for catching sharks was!

— *Health*

Snoring is a widespread complaint that afflicts only those who are not the patients, and only because they are so fortunate as to have good hearing. It is possible to draw two sound conclusions about snoring. The first is that snoring is repressible, even curable, when a definite cause-and-effect relationship is discovered. Something *can* be done about it. The other conclusion is that the agonized listener, helplessly adrift on a sea of snores, can always wear earplugs when everything else fails.

—*Health*

* * *

If you cannot get the habit of observation one way or other, you had better give up the being a nurse, for it is not your calling, however kind and anxious you may be.

—Florence Nightingale

(Continued from page 618)

She was on the teaching staff of the hospital at the time of her death.

* * *

Dorothy (Montizambert) Patterson who graduated from the Royal Victoria Hospital, Montreal in 1916 died on May 18, 1958. Mrs. Patterson served overseas during World War I with Taplow Military Hospital.

* * *

Fabiola Whelan, a graduate of the Royal Victoria Hospital, Montreal in 1906, died on May 4, 1958.

Acute Coronary Artery Disease

STELLA FLADER

SOCIAL AND FAMILY HISTORY

JAN KOWALSKI, 69 YEARS OF AGE, was born in Poland and migrated to Canada 30 years ago. Due to the inadequacy of educational facilities and dire financial circumstances in his native country, he received only an elementary education. This limitation of formal education and apparent lack of self-education, especially in regard to medical matters, seemed to manifest itself in the extreme anxiety that the patient showed concerning pain and his reference of all symptoms to his heart. When he experienced pain in a distal part of his body he would clutch his arms to his chest and cry out: "My heart — my heart — I'm going to die!" Such was the situation, for example, when he experienced "gas pains" in the abdomen that were soon relieved by an effectual enema, when he had "indigestion" pains in the epigastric region following the ingestion of a meal that he did not enjoy, and when he felt pain in his right arm that was later attributed to a previous dislocation of the right shoulder.

By occupation Mr. Kowalski was a carpenter, employed by a large firm. Although his remuneration seemed to provide for only a "minimum subsistence" level, he seemed fairly content in his employment situation because of the good relationships existing with his employer. He happily recounted the understanding and concern shown by his employer regarding a previous hospitalization. He did indicate on one occasion, however, that he had not achieved as much, financially or socially, as he would have wished.

To supplement his income, the patient received regular remittances from a son who is employed in New York City. His wife received a pension of $40 per month and since Mr. Kowalski is considered "legally blind" because of impaired vision, he also received a "blind pension" of $10 per week. Despite these additions to his income, his anxiety regarding his medical condition seemed to be intensified by worries regarding hospital and medical expenses.

The patient has three children, two sons and one daughter, all between the ages of twenty and thirty. He was usually visited by his wife and daughter. Often he would appear extremely restless and anxious in the early morning, becoming more optimistic, cheerful, relaxed and comfortable as the day progressed, reaching the optimum of such condition shortly before afternoon visiting hours. Upon the arrival of his family which he anticipated throughout the day, he would often become somewhat despondent and filled with self-pity. His wife and daughter indulged him in all of his complaints and showed extreme sympathy. It is suggested that perhaps this sudden daily change in his disposition may have been in the nature of an "attention getting" mechanism to obtain the love and affection needed to compensate for his feelings of physical and emotional insecurity.

FAMILY MEDICAL HISTORY

The patient's mother was thought to have died of asthma and his father supposedly died of old age. He has one brother and three sisters, all alive and well. One sister died, the cause of death being unknown. He has three children, all of whom are alive and well. There appeared to be no familial history of cancer, tuberculosis or diabetes mellitus.

PATIENT'S PAST HISTORY

Mr. Kowalski had no history of childhood or early adult illnesses. He smoked three or four cigarettes per day and took alcoholic beverages only occasionally. His ideal weight was 136 lb. and he had not shown recent gain or loss in weight.

He was first seen in the outpatient department in 1936. On that occasion he complained of a pain radiating from his forehead to the back of his head, following the onset of a "cold." Physical

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Miss Flader, an intermediate student at the Jewish General Hospital, Montreal, was awarded the first prize of $25 in the competition sponsored by the Macmillan Company of Canada.

and neurological examinations proved negative. Four fingers of the left hand were bandaged because of cuts and the patient stated that following the accident that injured his fingers, the pains in his head had developed. His heart was found to be "normal — of good quality and regular." The attending physician at that time entered his "impression" as "probable neuroses(?)."

Except for two minor complaints unrelated to the present illness, the patient was not seen in the intervening period until a few years ago. In 1953 he came to the outpatient department again with the complaint of epigastric distress following meals, especially in the evening following the large meal of the day. Some relief was obtained by lying down. There had been a gain in weight over a period of two years and the abdomen was obese. The diagnosis was "dyspepsia and obesity." The patient was placed on a reducing diet of 1100 calories and given a prescription for neotropine alkaline.

The following year he complained of pressing pain substernally, constipation with some red blood in the stools, anorexia and polyuria. There was no dyspepsia, vomiting or weight loss. A barium enema revealed some spasticity of the sigmoid colon. An electrocardiogram suggested auricular myocardial disease. The pressing sensation disappeared with medical care.

Several months later the patient complained of pain in the left side of the chest, stating that it was due to his stomach or possibly his heart. An electrocardiogram showed left ventricular enlargement. He also complained of headache, impaired vision and insomnia.

He first attended the cardiac clinic in 1955 following a sudden attack of constricting pain that was not severe but persisted for about two days. The diagnosis of hypertension was made. It was noted that his blood pressure, recorded in 1936 as 130/90, was 220/120. In subsequent visits to the cardiac clinic, the findings indicated left ventricular enlargement and auricular myocardial disease.

During 1956 he continued to complain of severe headaches and vertigo. An ophthalmological examination proved negative. A neurological consultant suggested the following: diffuse cerebral arteriosclerosis, hypertensive cardiovascular disease, or metabolic headaches. The patient was given neobarb, serpasil and largactil. In the following weeks it was observed that he progressed from a constant depressive state to one of near euphoria. In further visits, however, he complained of headache, constipation, insomnia and prolonged coughing.

In August of 1957 Mr. Kowalski was injured in a fall and suffered dislocation of the right shoulder and multiple right rib fractures. X-ray findings revealed dislocation at the acromioclavicular joint, fracture of the right third rib in its vertebral attachment and fractures to the third, fourth, fifth and sixth ribs in the mid-axillary line with moderate deformity. No surgical intervention was attempted because the patient was considered to be a poor surgical risk. After discharge from the hospital at the end of August the patient experienced intervals of pain referable to the rib and shoulder injuries.

Present Illness

A few days before the present admission, Mr. Kowalski suddenly experienced a "pressing pain" in the epigastrium that persisted for approximately five minutes and was then followed by a "burning pain" in the lower thoracic and epigastric regions. The patient was seen at his home by a doctor and given an injection that brought relief. Two days later a similar pressing and burning type of pain was experienced but it was restricted to the epigastric region. After being seen in the outpatient department, the patient was admitted to hospital as an emergency case with the diagnosis of "acute coronary artery disease with impending infarction."

Upon admission he appeared extremely apprehensive. He complained of frequent attacks of moderately dull pain in the epigastric region that appeared to be entirely relieved by codeine gr. ¼. His blood pressure was 174/110, his pulse was 68. Evidence of right shoulder separation was noted.

After a complete physical examination, the following differential diagnoses were made:

1. Coronary insufficiency
2. Gall bladder disease
3. Pancreatic malignancy

4. Hypertension
5. Shoulder separation.

On the basis of the admission diagnosis it appeared that the coronary arteries were to some extent occluded and unable to dilate sufficiently to supply the required volume of blood for the heart muscle. The almost continuous retrosternal chest pain of which the patient complained was attributed to the pain of angina pectoris that is usually associated with the clinical picture.

"With impending infarction" was noted as an integral part of the diagnosis because of the danger of arteriosclerosis rendering the coronary arteries susceptible to a blood clot formation. If the clot was sufficiently large to occlude a vessel, it would inevitably impede the blood supply to an area of the heart thus resulting in a "heart attack" or myocardial infarction. A history of hypertension was consistent with this diagnosis as were also the symptoms of headache, visual disturbance and general weakness and nervousness.

In acccordance with the clinical picture of myocardial disease, the patient frequently complained of gaseous distention and sleeplessness. However, other signs and symptoms such as orthopnea and albumin and casts in the urine were absent. Myocardial infarction was not indicated clinically. There was no fall in blood pressure to normal, no low grade fever, no findings of leukocytosis, no evidence of transient glycosuria and neither transient auricular fibrillation nor pericardial friction rub.

There was considerable doubt as to whether the pain was that of angina pectoris. It appeared at times to be paroxysmal. It would come on suddenly while the patient was at rest, following excitement, after voiding or defecation or after ingestion of a full meal. At other times it appeared to be almost continuous. The location of the pain seemed to vary frequently. Sometimes it occurred over the heart, in the epigastrium, retrosternally or radiating to the right shoulder and down the right arm. It was difficult to ascertain whether the latter type of pain was due to angina pectoris.

On certain occasions the patient would report relief from pain following administration of nitroglycerine gr. 1/100 sublingually; on other occasions there would be no relief whatsoever. The nitroglycerine tablets were left at the patient's bedside. He tended to take them frequently, often using three to six tablets consecutively, despite instructions and advice to the contrary. He insisted on having a supply of these tablets at his bedside at all times. It often seemed that their value lay in the psychological security that they afforded rather than in the relief of physical pain.

Pallor was usually evident. His blood pressure was constantly between 170 and 180 for the systolic. Mr. Kowalski's expression was frequently anxious and apprehensive and he often revealed a sense of impending death. Although these signs and symptoms were consistent with angina pectoris, such a diagnosis was not conclusive.

In accordance with the differential diagnosis of gall bladder disease, the patient did occasionally have dyspepsia following a meal that contained fatty foods. Aching pain and tenderness beneath the margin of the ribs on the right side and occasionally severe pain radiating to the back and right shoulder were experienced. However, the dyspepsia was not shown to be directly associated with the ingestion of fatty foods and the pain may well have been attributed to the previous rib and shoulder fractures.

Except for some loss of weight, anorexia and dyspepsia, the differential diagnosis of pancreatic malignancy was not borne out clinically.

Hypertension appeared to be associated with his heart condition and arteriosclerosis. The patient showed symptoms of extreme nervousness, apprehension and insomnia.

Tests

Routine tests such as a hemogram, urinalysis, feces analysis, biochemistry and serology were done. In addition, a gall bladder series, gastrointestinal series and frequent electrocardiograms were ordered and done.

The hemogram was done in order to determine such factors as the differential blood count and the quality of hemoglobin present in the red blood cells. The findings appeared normal except for a marked decrease in the number of white blood cells.

The urinalysis showed no significant changes except for an alkaline reaction.

Analysis of feces indicated a hard consistency that was in accord with the patient's complaints of constipation. The presence of blood in the feces may indicate such conditions as hemorrhoids, ulcers or cancer of the rectum, but the etiology of this sign was not pursued in this instance.

Biochemistry of the blood is done to ascertain its content. The only preparation required for this test is that the patient be fasting until the blood specimen has been taken, if the biochemistry examination includes an a.c. blood sugar. The higher than normal level of the a.c. blood sugar and the subsequent decrease in this level may have indicated faulty metabolism.

The negative findings of the Kline test indicated the absence of syphilis.

An electrocardiogram was done on the day of admission. As the patient had previously had such tests, the only preparation necessary was a minimum of explanation, proper posturing and adequate screening. The purpose was to obtain a graphic record of the electrical impulses produced by the activity of the heart muscle in order to arrive at a more accurate diagnosis of the particular type of heart disease. The findings of the first E.C.G. indicated "acute coronary insufficiency in the vertical heart with left ventricular hypertrophy." Electrocardiograms were done on six consecutive days and showed "minor continuing changes — compatible with active coronary disease." The final E.C.G., done approximately one week prior to discharge, indicated "little further change."

During the final week of hospitalization when the patient had recuperated sufficiently to be ambulatory, three sets of X-rays were taken.

Cholecystography was done in order to examine the functioning of the gall bladder by X-ray. On the evening preceding this test the patient was given a fat-free meal. Later in the evening he received Telepaque tablets orally. Nothing was given by mouth from this time until the patient was taken to the X-ray department the following morning. At approximately 6:00 A.M. on the morning of the test a soap suds enema was given but it was not very effectual.

The cholecystographic findings indicated that the gall bladder concentrated the dye very faintly. Unfortunately, visualization was impaired because bowel loops overlapping the gall bladder were filled with gas. It was recommended that this examination be repeated. However, this was not done as the findings did not appear to warrant further investigation of the gall bladder.

Upper gastrointestinal X-rays were done in order to visualize the structure and function of the esophagus, stomach, duodenum and small intestine. Nothing was given by mouth after midnight preceding the examination. An effectual soap suds enema was given on the evening before the tests. The X-ray findings showed the esophagus to be of normal length and of normal filling capacity. However, it was found that there was "a small herniation of the cardiac portion of the stomach through the esophageal hiatus." The stomach and duodenum otherwise appeared normal, as did the small intestine. The rate of motility was also shown to be normal. The "impression" noted by the radiologist was a "small hiatus hernia."

A barium enema was given in order to visualize the colon by X-ray. A laxative was given on the preceding evening and an effectual cleansing enema on the morning of the examination. Nothing was given by mouth after midnight. The findings from this investigation indicated "spasticity of the descending colon." The cecum appeared to be located in a relatively high position and tended to resist filling completely. The appendix was seen to be distinctly elongated and segmented although it appeared flexible and devoid of tenderness. The impression was: "Spastic colon" and "elongated and segmental appendix."

As a result of the X-ray examinations the attending interne recorded the following notation in the patient's chart: "The symptoms may be due to a diaphragmatic hernia rather than the chronic coronary insufficiency that he also has."

It should be noted that the herniation of a portion of the stomach through the esophageal opening in the diaphragm normally manifests the symptoms of pain shown by the patient in this instance — pain in the upper abdomen or chest, especially upon lying down after a full meal. However, the clinical picture of this condition also presents symptoms such as vomiting, hematemesis and anemia, all of which were absent. No further attention appeared to be given by the medical staff to the findings of "spastic colon" and "elongated and segmented appendix."

The prothrombin time was checked three times per week in order to determine the amount of time required for blood clotting. The purpose of performing this test with such frequency was to aid in regulating the dosage of anticoagulant drug therapy. It remained within the *therapeutic* range of 27-40 seconds. The normal range is 15 seconds.

Nursing Care

Upon admission to hospital Mr. Kowalski was given a "stat" dose of codeine gr. ¼ for the relief of pain in the epigastric region with apparently good effect and a dose of Danilone 200 mgm. orally as an anticoagulant for the prevention of thrombus formation, especially in the coronary arteries. The prevention of "impending infarction" was perhaps in large measure due to the anticoagulant therapy that consisted of almost daily doses of Danilone given orally in two doses of 50 mgm. and 25 mgm. respectively.

A 1500 calorie soft diet was ordered to prevent gain in weight, to facilitate mastication with dentures and to promote good digestion. This diet was continued until one week before discharge when the results of the upper gastro-intestinal X-rays indicated the presence of a hiatus hernia and other minor abnormalities. At this time the patient was given a bland diet.

Amphogel two drams was given on two consecutive days for complaints of "indigestion" and "heartburn" with questionable relief. This order was changed to Gelusil to be given one half-hour before meals and at bedtime. Moderate relief seemed to be obtained on several occasions, at other times no effect was evident.

Milk of magnesia one ounce was given once for constipation with moderately good effect. A soap suds enema was given on two occasions for complaints of "gas" with effectual results. A p.r.n. order was written for "Codeine gr. ¼ s.c." for chest pain. This medication was given almost nightly, the time of administration ranging from midnight to 6:00 A.M. The patient seemed to become dependent upon his "needle" and requested it regularly although the effects of relieving pain were somewhat dubious.

It frequently appeared that Mr. Kowalski had difficulty in expressing himself and in understanding others. This difficulty was occasionally evident during conversation in his native language, Yiddish. It was more frequently noted during conversations in English and it became intensely apparent during the night. The combination of such factors as fear of impeding death, impaired vision, financial worries and emotional insecurity made each dark, silent, sleepless night, a dreaded experience for the patient.

During the night he seemed to become more anxious, nervous, apprehensive and restless. He seemed to find more difficulty in expressing himself. In the morning, the day nurse would frequently find him lying awake — tense, apprehensive, extremely pale and apparently exhausted. Although the nurses' notes usually indicated "a good night," the patient frequently complained of insomnia, intervals of pain and fear of impending death. On some mornings he was so emotional that he would start to weep. The nurse would comfort him with sympathy and encouragement. She would give him complete early morning care, finish his bed bath, give him an alcohol back rub and change his bed linen as soon as possible. Within an hour the patient would frequently be sitting up in bed appearing more relaxed and cheerful.

During the first week of hospitalization Equanil tablet 1 was given orally four times each day to allay restlessness and apprehensiveness, with moderately effective results. Equanil was discontinued and phenobarbital gr. ½ t.i.d. was given. As this dosage did not seem adequate, the total daily dosage of phenobarbital was given in one dose at bedtime together with Sparine 50 mgm. As one of the most important problems in Mr. Kowalski's nursing care was the complaint of insomnia, various drugs were ordered and tried, all with dubious effects. Chloral hydrate gr. 10 was given on several occasions at bedtime until one evening when the patient complained of "heartburn" following the oral administration of this drug. On subsequent evenings Doriden tablets 2, Tuinal gr. 3, Chloralol gr. 10 and Donnatol tablet 1 t.i.d. before meals and at bedtime were tried. None of these drugs seemed satisfactory for the total relief of insomnia.

On the first night of hospitalization the patient objected to the presence of bedside rails. After the nurse explained to

him that they were safeguards for his own protection, he accepted them willingly and, in fact, he even requested that they be put up on subsequent nights.

Because of the apparent psychological dependence upon medications and because of the pattern of symptoms shown by the patient and the elusiveness of precise diagnosis, various attending doctors suggested the possibility of a psychoneurotic basis for the patient's complaints.

Mr. Kowalski received routine nursing care and ordinary comfort measures. Blood pressure and pulse were taken four times each day. The readings oscillated continuously, the blood pressure ranging from 140/90 to 210/120 and the pulse rate varying between 60 and 82 beats per minute. Daily intake-output records showed no significant deviations from the normal. Temperature and respiration were normal throughout hospitalization and his weight remained constant at approximately 142 pounds.

To promote mental well-being, nursing care included sympathy, understanding and a genuine interest in the patient's familial relationships and personal problems. He was very responsive when such interest was shown and appeared much more relaxed and cheerful after discussing his problems and receiving encouragement regarding the outcome of his condition. The day nurse met the patient's wife and daughter during afternoon visiting hours and made a special effort to greet them each afternoon. This pleased the patient and seemed to bridge the gap for him between his home and the hospital.

The nurse frequently explained to Mr. Kowalski the reasons for bed rest, proper nutrition, mouth care and regular cleansing of dentures; the taking of medications as prescribed by the doctor; and the inadvisability of frequent use of patent medicines not prescribed by a doctor or the very frequent use of nitroglycerine tablets.

When the patient was permitted to sit out of bed for the first time, he was extremely pleased and elated and wished to begin walking immediately. The attending nurse explained to him why it was essential that sitting out of bed and eventual ambulation be taken in gradual stages.

When the patient was discharged he was advised to obtain adequate rest and avoid exertion, to remain on a bland diet (a copy of which was given to him) and to return to the medical clinic of the outpatient department in two weeks (an appointment was made for him). He was given instructions about taking medications.

Future Problems

Mr. Kowalski's records indicated that the condition of acute coronary insufficiency had not been improved. The hypertension and the dislocation of the right shoulder were not treated but the diaphragmatic hernia had been improved somewhat. Handicapped by these conditions and other impediments such as impaired vision and approaching "old age," he returned home to a modest flat where he and his wife live alone. He is now "unemployable." He does feel a sense of inadequacy and tends to be depressed because of his enforced idleness and economic dependency.

Resume

In the course of caring for this patient I became acutely aware of the dynamic interrelationships that may exist between the individual's psychological disposition and his physiological manifestations. The anxiety, fear and apprehension experienced by Mr. Kowalski intensified such factors in his physiological condition as hypertension, heartburn, and retrosternal pain. The latter, in turn, served to further increase his anxiety, fear and apprehension.

It was necessary to attempt to understand him as a patient in his total environment, to be aware of all of the psychological, physiological, physical, familial, social, economic and spiritual factors affecting him. Viewed in this way it seemed that there was no factor, that could be entirely excluded from the scope of the nurse's responsibility and understanding. Anxiety regarding finances, fear of death, apprehension of new surroundings, concern for family and loved ones and despair concerning one's own dependency, all contributed to hinder recovery.

The time and effort devoted to understanding sympathy and interest in the patient's family and problems were richly rewarded.

The possible complexities involved in diagnosis were made evident. An admission diagnosis may afford only a tentative starting point leading to the subsequent discovery of a multitude of other contributing factors.

Unfortunately, discharge is not necessarily synonymous with recovery. The patient may return home to face acute financial, physical, psychological and social problems. It would seem that all of the principles observed in caring for this patient may well be applicable in varying degrees and with various modifications, to almost every conceivable nursing situation.

Traumatic Arthritis of the Hip

JOAN LAWRENCE

MR. JAMES was a 43 year-old man with a wife and two teenage sons. Until 1940 when he joined the army he had been employed as an overseer in a coal mine, receiving an adequate wage and enjoying very good health.

During the Second World War, in June 1942, the jeep in which he was riding was overturned, pinning him beneath. He sustained a fracture of the left side of the pelvis and extensive injury to the left hip joint although no fracture was evident. On continuous bed rest the pelvis knitted well, but the hip did not completely return to normal, and in 1943 he was honorably discharged with a disability pension from the army.

Several months later, Mr. James returned to the coal mine and to his original job, as the income from his pension was inadequate to support his family. The coal mine was short of laborers, and well able to pay a good wage. For several years the work in the mine did not aggravate Mr. James's hip, although he had a slight limp and pain was present following a hard day's work. Perhaps it was due to tension or worry, that in 1946 he developed stomach ulcers. These responded well to conservative treatment.

Gradually the hip pain became worse until Mr. James felt that he could no longer continue such a strenuous type of work unless something could be done to relieve him of the pain. A few days later he consulted the Department of Veterans Affairs (D.V.A.) physician in the nearest city.

Eventually, he was referred to an orthopedic surgeon. The doctor made a thorough examination of the hip and pelvis and ordered several X-rays which were taken in his office. The following observations were recorded.

Subjective findings:

1. Patient complains of a limp, stiffness and progressive pain in the left hip over the past 14½ years following a war injury.
2. This pain is increased by activity or dampness and improves with rest.
3. This pain radiates down to the knee, and upward to the left axillary region.
4. After standing or sitting, or when starting to walk, a catching sensation and pain develop in the hip joint.
5. Considerable wasting of muscles about the hip is noted and muscle spasm is present.
6. Patient has been treated for duodenal ulcers, which developed 11 years ago. These give him distress between meals periodically, but are relieved by milk or food and have caused no hematemesis.

Objective findings:

1. Patient walks with left hip limited to twelve degrees flexion and beyond this point, pain develops.
2. Adduction is markedly limited, and the left leg is fixed in a slightly abducted position.
3. Left leg is slightly shorter than right.

Miss Lawrence is a student at the University Hospital, Edmonton. She was awarded second place standing in the competition sponsored by the Macmillan Company of Canada.

4. Left knee reflex is diminished.

5. Pain is present on pressure about joint.

6. X-rays show joint space narrowed, with lipping of both acetabulum and femoral head, with the head somewhat flattened and distorted.

Dr. Sloan showed Mr. James the X-rays he had taken and explained to him that a condition known as traumatic arthritis was present in his left hip. This would become progressively worse if untreated and he advised surgery of a reconstructive type to lessen the pain and give a greater degree of mobility. This might be accomplished by removing the diseased head of the femur and replacing it with a metal head.

Arthritis is a joint affection characterized by inflammation and changes varying with the type.

"Traumatic" arthritis may develop in any joint as a result of an injury to the articular cartilage and is followed by degenerative changes particularly in weight-bearing joints. The synovial membrane of the joint thickens and scars. There may be erosion through the articular cartilage and the underlying cortex becomes deformed and eburnated. At the edge of the cartilage, however, new bone forms a lip. This causes limitation of joint movement and pain. Bony spurs, or pieces of this lip may break off and form loose bodies within the joint capsule. Adhesions develop around the joint, with subsequent stiffness and pain on continued exertion, that is somewhat relieved by rest. In many cases the sedimentation rate is elevated due to the chronic inflammation present in the joint. Wasting of muscles about the joint, due to disuse, and postural deformities are not uncommon.

Mr. James was admitted to the male orthopedic unit of the D.V.A. Hospital. He was introduced to the patients with whom he shared a cubicle and seemed to adjust readily to his surroundings. As he had spent considerable time in hospital during the war, he was accustomed to the routine. Before Mr. James was made comfortable in his bed, a split fracture board was applied. This was done to prevent sagging of the mattress and postural errors. Following an examination by the intern, further X-rays were ordered of both hips and Mr. James was booked in the operating room for "left hip arthroplasty."

Arthroplasty, as the name implies, from "arthro" meaning "joint" and "plasty" meaning "plastic," is the surgical reconstruction of any joint. It is done in cases of severe joint damage, where motion in the joint has been lost, or where movement causes pain. The diseased portion is removed and replaced by a metal prosthesis. This prosthesis will vary in shape according to which joint is involved and the size of the joint. Arthroplasty is done most commonly on the hip joint, as it is a large weight-bearing joint receiving much stress and strain and is so frequently affected by trauma or inflammation.

Hip arthroplasty was first attempted by Dr. Jean Judet, a French orthopedic surgeon. Much credit must be given him for advancement in hip reconstruction, and for the freedom from pain and freedom of movement enjoyed by many people who would have otherwise been incapacitated due to hip injury or affection. It is for this reason that hip arthroplasty is frequently incorrectly termed a "Judet Operation." The hip prosthesis used in arthroplasty is made of stainless steel. It somewhat resembles a mushroom, in that there is a head, which is ball-shaped to replace the head of the femur, and a neck to facilitate stabilization of the prosthesis into the femoral neck.

The initial prosthesis devised by Judet, was made of plastic, with a straight, fairly short neck. Following several cases of broken prosthetic heads, stainless steel replaced the plastic head and has proved much more satisfactory. In certain cases, where the femoral neck is destroyed, as in an ununited fractured neck of the femur with necrosis of the head, another larger prosthesis may be used. Several types are available. Each includes a head, neck and shaft that may be stabilized into the medulla of the femur. These prostheses are very strong. Some are claimed to be able to stand under any weight up to five hundred and twelve pounds.

In cases of traumatic arthritis, arthroplasty is attempted primarily to relieve pain. The younger the patient the better the recovery, although there is considerable controversy as to the duration of time a joint will stand up following arthroplasty, due to constant use over a

period of years. So far the present patients are selected from the older age group, unless the necessity for earlier reconstruction is apparent.

Generally, in cases of arthritis of the hip results show around 65 per cent excellent, and 35 per cent fair or poor. The selection of the patient is most important. He must show will power and energy and be willing to give full cooperation. If any of these qualities is lacking arthroplasty should be ruled out. Patients with a neurosis, or a questionable mental state should be rejected. They are warned not to expect miracles and told that they should not expect over 80 per cent of the original hip movement postoperatively.

Preoperative Preparation

Preoperative preparation for Mr. James commenced the day prior to surgery. Blood cross-matching was done. A medical specialist was consulted and checked Mr. James carefully to assure Dr. Sloan that his general condition was adequate to undergo major surgery. The patient was encouraged to drink all the fluids he could that day to compensate for fluid loss during the operation. The shave preparation was done by the orderly. It was a very large area including the affected side from the nipple line to the toes, midline to midline.

A cleansing enema was administered to prevent defecation during surgery and contamination of the operative area, and to remove flatus and intestinal contents from the lower bowel as they predispose to postoperative gas formation and distention. The patient then had a hot tub bath. The charge nurse checked the skin shave carefully and a student nurse applied an orthopedic skin preparation to the area that consisted of Germa Medica containing G 11. This preparation is applied to make the area as surgically clean as possible.

Mr. James was instructed not to drink any fluid after midnight. To ensure a good night's rest Nembutal gr. ¾ was given to him. He knew of no previous reactions he had had to any drugs.

The morning of surgery, breakfast was eliminated. Special mouth care was given to prevent postoperative respiratory infection such as parotitis. The patient was dressed in an operating room cap, socks and gown and instructed to void before receiving his preoperative sedation of morphine gr. 1/6 and hyoscine gr. 1/150.

Postoperative Care

While Mr. James was in the operating room the unit was prepared for his return. A single overhead frame and trapeze were placed over the bed. A long rubber sheet was placed beneath the bottom sheet to protect the mattress, as much oozing was anticipated. Several rubber-covered pillows were in readiness. Blood pressure apparatus, spinal bed pegs, kidney basin and cellulose wipes were available. An intravenous standard was brought to the bedside and the portable oxygen tank was checked for use if required.

Following surgery, Mr. James remained in the anesthetic recovery room until he regained consciousness. On his return to the nursing station at 1:00 P.M. the orderly and one student nurse were summoned by the charge nurse to assist in moving the patient from the stretcher to his bed. She had explained previously in morning circle that when hip arthroplasty is performed, one of the most important points in the nursing care is to prevent dislocation of the new head from the socket by adduction. To prevent this, the leg must at all times be kept in abduction and the foot in internal rotation to prevent strain on the hip capsule. To maintain the correct position Dr. Sloan had put plaster boots on Mr. James with a spreader bar between them, keeping both legs in abduction. Care had to be taken to prevent damaging the casts when moving him, and to avoid dislodging the intravenous which was running.

Checking the operating room record it was discovered that Mr. James had received 1000 cc. of blood during the surgery and, following this, 1000 cc. 5 per cent glucose in water had been attached. When absorbed this terminated intravenous infusions. The anesthetic given had been pentothal and nitrous oxide. A modified Judet prosthesis had been inserted into the hip.

Mr. James's general condition postoperatively appeared good. His blood

pressure recorded 116/80, which was somewhat lower than his admission record. The pulse was stable at 86 beats per minute. Although he was conscious, he was still quite sedated and complained of no pain. The plaster boots were left exposed, to allow the air to circulate around them and dry them evenly. It also permitted the nurses to check the circulation in his toes every half hour, but there appeared to be no edema or circulatory disturbance present. The plaster crumbs were washed off and oil applied to the toes.

During the afternoon slight oozing appeared on the large hip bandage. It was reinforced with padding. There was no indication of excessive bleeding. Morphine gr. 1/6 had been ordered and was given almost every three hours for the first two postoperative days to relieve severe pain. Untoward reactions such as nausea, vomiting and restlessness were watched for carefully. As soon as possible Mr. James was given a compound of aspirin and codeine, two tablets q. 4 h. p.r.n. Much of the pain appeared to be due to muscle spasm about the hip. Dr. Sloan ordered Tolserol, a skeletal muscle relaxant, gr. 1 t.i.d. with meals. The nurses were warned to observe carefully that no muscular incoordination or weakness developed as a result of an untoward reaction to this drug. It was administered for five days. Neurotrasentin forte, tablets I, t.i.d., a.c. and h.s. were ordered when the Tolserol was withdrawn. Dr. Sloan felt it might help the patient to relax. Ten days after operation, all drugs were discontinued. They were no longer required and Dr. Sloan wished to prevent any addiction or habitual use of drugs.

For the first few mornings the nurses gave Mr. James his daily bath. It was not long until he was able to do his own bath with the exception of his back and legs. Special care was given to both feet. They were washed and oiled twice a day. This was the routine followed for all patients wearing casts. Mr. James kept himself well-groomed. He was very cooperative and anxious to help himself despite his limitations.

It was during his routine daily care that the nurses impressed on Mr. James the importance of moving about, of taking deep breaths, and of forcing fluids to prevent such complications as hypostatic pneumonia or kidney stones. They stressed the importance of good posture while lying in bed just as in standing and encouraged movement of all uninvolved joints daily. On the third postoperative day the charge nurse taught Mr. James to do static quadriceps drill on both legs. She stressed the importance of keeping all muscles in good tone — particularly the large muscles of the legs, and those of the shoulder girdle that would be required for crutch walking. Mr. James was anxious to progress and could be seen at regular intervals practising his exercises.

Due to the fact that he spent a great deal of time lying on his back, and because he was wearing plaster cast boots, good care of the patient's skin was of prime importance. A rubber air ring, partially inflated, was placed under his buttocks for periods, but not constantly. To permit back care, particularly over the coccyx, he was permitted to raise himself straight upwards by means of the trapeze, while his back was washed and rubbed morning and evening. Additional massage with alcohol and powder was given every four hours. The large hip bandage became matted and hard from the serosanguinous discharge during the first few days postoperatively. It was removed on the third day and allowed better back care to be given. The casts caused very little irritation to the skin of the legs and feet.

For a change of position Dr. Sloan permitted Mr. James to be turned for short periods on his right side. This had to be done in one movement to avoid twisting at the hip. To keep him in this position the spreader bar was suspended from the overhead frame by means of a rope. The upper gatch of the bed was also elevated for short periods for a change of position, but lowered again to prevent any hip contractures, that might have developed had he remained constantly in a flexed position.

Immediately postoperatively Mr. James was placed on a fluid diet, then diet as tolerated. Because of his previous stomach ulcers, milk was kept at the bedside at all times. He had some difficulty digesting certain foods on the regular diet, and was placed on an

ulcer diet. This eliminated coarse cereals, strong vegetables, fried foods, spices or excessive salt and he managed well, with little epigastric discomfort.

Nine days after surgery, Dr. Sloan removed the skin sutures. The wound was clean and well healed. There had been no indication of any infection for his temperature remained in normal range after the first 24 hours.

On the same day that the sutures were removed, the plaster boots were bivalved and cuffed, but not removed. A pulley attachment was set up from the spreader bar, allowing the patient to exercise his legs up and down in the casts. Gradually the doctor allowed Mr. James to have the cast removed for short periods during the day. They were replaced at night. At the end of two weeks the casts were discarded. Two pillows were placed lengthwise between the legs to keep the affected hip in abduction. Several pillows were required when the patient was turned to his right side to keep the left leg in correct position.

More active physiotherapy was commenced. Gluteal muscle exercises were taught by the physiotherapist who came twice daily to the nursing unit. These exercises applied only to the uninvolved hip. They were accomplished by pinching the buttocks together and attempting to move the leg to the side of the bed. A few days later hip mobilization was commenced in the Department of Physical Medicine in the form of heat, gentle massage and passive motion. This gradually progressed to active exercises to restore a good range of motion in the affected hip. At first the patient was transported to the department by stretcher until he became quite independent and was allowed to go by wheelchair. Three weeks after surgery, weight-bearing on the affected hip was commenced and the four-point crutch walking gait was taught to Mr. James by the physiotherapist. This gave him much encouragement for he was experiencing much less pain than he had felt for some years. In a short time he was allowed to bring his crutches up to the unit with him and walk about the ward on crutches as much as tolerated.

The nurses checked Mr. James to see that he maintained correct posture, keeping his head up and chest forward when using his crutches. They stressed the fact that the weight must fall on the hand-bar rather than the axilla-bar explaining the danger of "crutch paralysis." He was warned to be sure that the rubber tips on the crutches fitted snugly and were not worn down, as this might cause serious accident. New tips, or crutches, might be ordered through the hospital if needed.

Approximately four weeks after his operation Mr. James was discharged to continue his convalescence at home. The doctor warned him to report immediately if he experienced any sudden pain in the hip or developed any complications. Slipping on ice or scatter rugs might prove very dangerous and these hazards should be avoided.

Conclusion

Mr. James's reaction to his illness and hospitalization was excellent. He was not the type to develop "hospitalitis," but was anxious to become ambulatory again and be a useful citizen in his community. He was vastly interested in the social life of his family and took fatherly pride in his sons. His ambition appeared to be centred around participating in dancing and social activities from which he had been deprived.

Mr. James appeared to have strong religious convictions and was visited frequently by his minister. His excellent adjustment to his illness no doubt reflected back to his religious faith for he remained calm and appreciative, where many a patient would have been discouraged and demanding. It was unfortunate that he could not have been nearer home, so that his wife might have been able to visit him more frequently. However, her letters arrived regularly.

He followed a fairly normal course with no serious complications and definitely benefited by the surgery performed. Such complications as shock, hemorrhage, dislocation, phlebitis and pneumonia were no doubt prevented by prophylactic measures and continuous conscientious nursing care.

A certain amount of rehabilitation will be required for Mr. James for it is questionable if he will be able to return to as strenuous a type of work as

mining. He is a comparatively young man, with a good prognosis, and his future will be spent in some worthwhile position, if he is given the proper opportunity. He was referred back to the company physician at the coal mine, so that he might be given consideration for re-employment if his condition permitted heavy work following convalescence.

Community agencies such as the Special Placements Section for Handicapped of the National Employment Service may be of some assistance to him. The Department of Veterans Affairs with its War Veterans Allowances, Disability Pension, Employment, Rehabilitation of Disabled Veterans, Re-establishment of Credit and Veterans Insurance have come to his aid in the past and will no doubt do what they can to help Mr. James.

Today, when so much concern is shown regarding the welfare and usefulness of our ever-increasing numbers of senior citizens, hip arthroplasty has made a decided contribution to medicine. The majority of people requiring this type of surgery are in the older age group and would have been incapacitated due to increasing pain from osteoarthritis. These aged people now have the opportunity to enjoy many years of pain-free existence, taking their place as happy, useful citizens in the community.

In the Good Old Days

(The Canadian Nurse — JULY, 1918)

As she welcomed the members of the "Canadian Association of Nurse Education" and the "Canadian National Association of Trained Nurses" to Toronto for their annual convention, Miss M. A. Snively said: "In the words of our late honored Florence Nightingale, when bidding farewell to a nurse friend of my own, then at the head of a large training school in New York, I now repeat 'Into the future open a better way.'"

* * *

Discussion on the Report of Committee on Standard Curriculum brought out the lack of any place in Canada where nurse instructors could be trained. Miss Gunn proposed the theoretical training of all nurses to be done in the large hospital of a district, with a certain amount of time in the second and third years to be spent in smaller hospitals.

* * *

McGill University has opened new doors to women. They are to be admitted to the study of medicine and dentistry.

* * *

Approximately two per cent of the school population were discovered to be diphtheria carriers — the majority being nasal carriers.

* * *

The public has been educated to go to the doctor and pay him for medicine and not for advice . . . Some wise doctors keep on hand some harmless colored sugar pills to give for the dollar, and give good advice gratuitously.

A new concept in hospital beds has been announced by the Franklin Hospital Equipment Corporation, Newark, New Jersey. It is felt that it will have particular value in the treatment of patients with cardiac complications and where postoperative and physical therapy treatments are required. The design of the new bed conforms to hospital specifications and includes the desirable feature of reduced bed height making transfer to a wheel chair easier and giving the patient a greater sense of security. All standard hospital bed positions are easily attainable but there is a full range of motion from 10° Trendelenberg to 90° or full standing position. The patient can walk on or off the foot rest from the bed's full standing position. There is a complete line of accessories available that will increase the uses and range of treatment possible with this bed.

* * *

Mrs. Mary McAlister, a former president of the Glasgow Branch of the Royal College of Nursing, has become the first nurse in the British Isles to be elected a member of parliament. She was the successful candidate in the recent by-election in Kelvingrove, Glasgow. —*Royal College of Nursing report*

Bilateral Cataracts

JOAN (VANCE) PURVIS

A CATARACT IS AN OPACITY of the crystalline lens of the eye or its capsule. As the rays of light entering the eye must pass through the pupil and the lens to reach the retina, any opacity of the lens behind the pupil will produce an alteration in vision. Therefore this disease is associated with a progressive loss of vision.

It may be caused by nutritional or inflammatory changes in which the normal development has been affected during growth, as seen in congenital or juvenile cataracts. It may be due to degenerative changes from various systemic conditions such as diabetes, hypertension and hypocalcemia, or poisoning. It may also be due to trauma, radiation or exposure to intense heat. Cataract may be associated with some other disease of the eye. Heredity plays an important role as it did with the patient in this instance.

Expectant mothers who contract german measles (rubella) in the first trimester of their pregnancy may transmit the disease to their child *in utero*. This often leads to the development of cataracts among other congenital conditions. Senile cataracts are the most common. They, as well as those caused by nutritional changes, systemic disease and heredity are usually bilateral. Senile cataracts occur in patients over fifty. They may, however, occur in younger persons.

Various theories have been propounded as the cause of senile cataracts. Some believe that cataracts are a normal phenomenon of aging, comparable to graying of the hair. Others believe that they are evidence of factors in the general condition, such as abnormalities in metabolism, requiring medical care.

The chief symptom of cataracts has already been mentioned — a progressive loss of vision. Other symptoms are due to further involvement of the eye, such as secondary glaucoma and inflammation. In such cases the symptoms are pain and redness. Unfortunately it is often these later symptoms that bring the patient to seek the care and advice of a doctor.

The prognosis, if the patient is treated by a qualified ophthalmologist, is good. It depends however, on the condition of the macular region, the presence of glaucoma, detachment of the retina and degenerative processes. The prognosis is more favorable in acquired cataracts, than in congenital cataracts. In any treatment other than an intracapsular cataract extraction, in which the lens or its contents is removed but the capsule is left in place, there is always the possibility of recurrence. This is often the case in patients who have congenital cataracts.

In congenital cataracts the treatment is usually "needling" — a surgical procedure in which an opening is made into the lens. This allows the aqueous humor to flow in and it will absorb the lens matter. Congenital cataracts are very prone to recur in which case a second needling must be done. This is called a "discission." Glasses with double-vision must be worn by the patient for the rest of her life. In many cases with surgical treatment, followed by a fitting with proper glasses, the patient is able to see fairly well.

PATIENT'S HISTORY

Mrs. Smith was a 37-year-old happily married Canadian housewife. Her husband was a brakeman for the Canadian National Railway. She had one daughter 10 years of age. The patient was a financially and socially secure individual who appeared to be emotionally mature. She had had a normal childhood and adolescence. Her personal history showed no physical illness except for the usual childhood diseases of roseola, chicken pox and mumps. The family history indicated however that two aunts and a sister of the patient had had cataracts at an early age. Remembering the age incidence of cataracts

Mrs. Purvis was a senior student at the General Hospital, Belleville, Ontario, when she prepared this study. She received an Honorable Mention Book prize in the Macmillan Award Competition.

this patient was one of the few who have cataracts early in life.

The history revealed a gradual fading of her vision during the last two or three years. During the last few months prior to her admission to hospital the loss of vision in the right eye became alarming to the patient and she consulted her local ophthalmologist. Examination showed a dense cataract of the right eye and early changes in the left eye.

Laboratory examination of the blood showed no deviation in the blood calcium, the normal being 9-11 milligrams per 100 cubic centimeters of blood. Had the blood calcium been abnormally low it would have indicated hypocalcemia, a possible cause of cataracts. A fasting blood sugar test showed a level of 100 milligrams of dextrose per 100 cc. of blood, the normal being 70-120 milligrams per 100 cc. of blood. Her urine was negative for sugar on testing it with Benedict's solution. This ruled out the possibility of diabetes mellitus, another cause of cataracts. A complete blood count was done, but it also was normal. There seemed to be no systemic disease present requiring medical care. There was no history of radiation or exposure to intense heat.

Ocular examination showed signs of hypermaturity in the cataract of the right eye with little light perception and complete loss of vision. There were early changes in the left eye but light perception and vision were still good. The hypermature cataract of the right eye was entirely a surgical problem.

Mrs. Smith was admitted to hospital for an intracapsular cataract extraction of the right eye.

Preoperative Preparation

This consisted of a soap suds enema at bedtime to clear the bowel as a patient is allowed to go at least four days postoperatively without having a bowel movement to avoid strain on the affected eye. The eyelids and skin area including the eyebrows were washed with green soap. Mrs. Smith was given a bedtime sedative of Nembutal gr. 1½ to insure a good night's rest. She had nothing by mouth after midnight to prevent nausea and vomiting after the operation and to avoid strain on the suture line.

In the morning Mrs. Smith had Nembutal gr. 1½ two hours preoperatively. This sedative was for the purpose of relaxing the patient and thus making the stronger drugs to follow more effectual. A milder sedative, Seconal gr. ¾, was given one hour preoperatively for the same purpose. The Seconal was given with Largactil 25 mgm. This is a tranquillizing drug and calms the patient relieving her apprehension and tension. Demerol 50 mgm. was given intramuscularly a half-hour preoperatively.

Demerol is a synthetic preparation. It has an antispasmodic effect explained in part by its parasympathetic blocking action, but chiefly due to a depressant effect on muscle fibres. It is said to be midway between morphine and codeine in its analgesic action. It lasts between five and six hours. Mrs. Smith was quite lethargic when the operating room staff called for her.

The treatment in a case such as this depends upon the age of the patient, the consistency of the cataract, and the presence of intraocular complications. Mrs. Smith was only 37 so there was a possibility of recurrence if the lens and its capsule were not removed. The lens of this right eye was hypermature and a slight inflammatory condition of the eye was already present. The lens at this point was a soggy sac. An intracapsular cataract extraction with two peripheral iridectomies were done.

A peripheral iridectomy is the removal of a wedge-shaped piece of the iris at the outer edge and not completely through to the pupil. This is done first so that the surgeon could grasp the lens with a forcep and remove it. The iridectomies also promote drainage after the operation thus preventing synechia. These are adhesions between the ciliary body and the iris that block the escape of aqueous humor with resultant glaucoma.

The hypermature lens was ruptured during removal and the second iridectomy enabled the surgeon to grasp and remove the remaining part of the lens and its capsule. The entire operation was done through an incision into the retina, barely outside the cornea. The incision was closed by fine black silk sutures.

The procedure was carried out under local anesthesia. Preoperatively Mrs. Smith had eye drops of 10% neosynephrine and 5% homatropine every 10

minutes for four doses. On reaching the operating room a special anesthesia of Pontocaine was used to produce loss of sensation.

The drops of 10% neosynephrine acted as a vasoconstrictor on the eye and prevented hemorrhage. The drops of 5% homatropine dilated the pupil and caused paralysis of the muscles of accommodation of the eye. Novocaine was injected around the eye blocking the nerves supplying the muscles closing the eye, the muscles producing movement of the eyeball and producing loss of deep sensation. The surgeon had a still field in which to work and the patient received no sensation.

The fact that the operation is done under local anesthesia explains the necessity for heavy preoperative sedation. Even though Mrs. Smith was given much reassurance and explanation she was still quite apprehensive because she knew she would not be having a general anesthesia. She was afraid of the outcome of the operation even though she knew she was getting the best possible care and that the prognosis in her case was good.

Postoperative Care

Postoperatively Mrs. Smith had eye ointment applied by the doctor when he changed her dressings. This was done for the first time the day after her operation and daily thereafter. Neocortef ointment was used to prevent infection that might occur due to the rupturing of the lens in removal. Some authorities say that the ointment slows the healing process but Mrs. Smith's ophthalmologist felt that this was true only to a small degree and that it should be used in her case particularly. The eye did heal at a favorable speed. Atropine ointment was also used and produced paralysis of the muscles of accommodation thus keeping the eye at rest and preventing complications.

Possible complications were hemorrhage, iris prolapse, flat anterior chamber, and infection. The nursing care that Mrs. Smith received played a major part in her rapid recovery and the prevention of complications.

Nursing Care

Mrs. Smith, even though she appeared to be an emotionally secure individual, was very apprehensive. She was a young woman with the responsibility of caring for a little daughter and a home, and her problems seemed very great to her. There was time for discussion, so the operative procedure was explained to her in simple terms that she could understand. She was instructed as to what she might expect postoperatively.

1. She had to be absolutely quiet since any sudden jar might destroy all that had been accomplished in surgery.
2. She must be fed, washed and turned by the nurse.
3. She was told where such things as Kleenex, call bell and paper bag would be situated.
4. She must have only a low firm pillow.
5. She must not strain at stool.
6. When able to get up she must not bend over.
7. She must not rub or squeeze the eye.
8. She must be careful not to bump into anything when walking about.
9. She must avoid sudden movement, strenuous exercise and reading until given the doctor's permission.
10. She must avoid psychological upsets. In this respect the family were instructed to leave their troubles at home when visiting her.
11. She must avoid coughing, sneezing, vomiting or laughing.
12. Mrs. Smith had shampooed her hair prior to admission. It was well combed and brushed the morning of the operation. She was also given good mouth care and told that she must not brush her hair or teeth after the operation until the doctor ordered it.

Mrs. Smith's questions were answered intelligently by the nurse. Mrs. Smith worried about the fact that in the future she might have to have a similar operation on the other eye. She wondered if her sight after these operations would be adequate for her to continue her duties as a wife and mother. She was reassured that she would be fitted with glasses postoperatively, and that with these glasses she would be able to see well. She was also told that her prognosis was good.

Mrs. Smith expressed fear because she knew that the operation would be done under local anesthesia. She was told that she would be given sedation

preoperatively and that she would feel nothing at all. The importance of a good night's rest before the operation was stressed so that she would not be tense and tired. She did have a good night's rest with the assistance of the Nembutal that was given to her at bedtime.

Her own nurse went with her to the operating room to give her added reassurance. Then the anesthetic bed was made in the usual manner and her bedside articles were placed in the position that Mrs. Smith was told they would be.

On returning from the operating room she was placed flat on her back with a small firm pillow. Mrs. Smith had a mask over both eyes but this was not alarming to her as she had been told of this preoperatively. Since she could not see it was important that any one entering the room should announce her arrival and departure. During the first two days a total bed bath was omitted to prevent excessive movement. The patient was given good mouth care and fluids only for the first 24 hours to prevent any movement caused by chewing and also to prevent nausea and vomiting. When it was necessary for her position to be changed, she was turned by two nurses and even this was not done until after 24 hours. After the first day, Mrs. Smith was given a soft diet omitting all foods that would cause flatulence. Any effort to expel flatus might cause a sudden jar to her eye. For the same reason foods with bones and pits were also omitted later. A rectal tube could have been used to help expel flatus if necessary. Mrs. Smith was fortunate in having no difficulty of this sort.

For the first two or three postoperative nights, Mrs. Smith received codeine gr. 1 to relieve her pain. Codeine was used because it does not cause the nausea and vomiting that may occur with the use of morphine and it does not produce hypnosis. It was given as soon as the pain occurred as any delay might have upset the patient psychologically and produced restlessness.

It was necessary to repeat postoperatively those points covered in teaching Mrs. Smith preoperatively, just to make sure she did not forget them. In spite of all this teaching, on her third postoperative day she became very depressed. The nurse spent a great deal of time talking to her, discussing her problems and reassuring her. Mrs. Smith's clergyman was of much assistance. He visited her on several occasions and gave her that added assurance which only he could give. The spiritual aspect of nursing care should never be overlooked.

The nurse observed closely for any symptoms of ocular bleeding such as a feeling of pressure or a "picking" sensation. The dressing on Mrs. Smith's eye was changed daily by the doctor. A phobia caused by both eyes being covered is one of the main possible complications in a cataract extraction. The patient becomes confused, tries to get out of bed and attempts to tear off the eye dressings causing damage to the eye. This fortunately was not a problem with Mrs. Smith. After about the third day she was able to have the mask removed for a few hours at a time. It was left off a little longer each day, until she was able to go home, wearing the mask only at bedtime as a protection while sleeping. The eye pad, however, was left in place.

Each time the dressing was changed the suture line and surrounding tissues were examined for any signs of infection. Her sight was checked from time to time by asking her to count fingers on the doctor's upheld hand. Her progress was satisfactory and on the 10th postoperative day she was allowed to go home.

The health teaching given to her on discharge was as follows:

1. She must make follow-up visits to the doctor so he could check her progress.
2. She must not touch her eyes without first washing her hands.
3. She must make sure the dressings are clean at all times and keep the eye pad over the affected eye until removed by the doctor.
4. She must not work until she has the doctor's permission. The family was instructed as to how much Mrs. Smith would be able to do when she went home.
5. She must wear the mask over her eye at night to prevent striking it in her sleep.
6. It was explained to her that she must give good care to her left eye. She was told by the doctor to watch for any further loss of vision in her left eye which might indicate that the immature cataract in that eye was maturing.

7. She was told that in about six weeks she would be fitted with glasses.

8. She was instructed to wear dark glasses while out in the bright sunlight for the first three or four weeks.

When Mrs. Smith returns, if necessary, to have a cataract extraction of the left eye, her apprehension will be at a minimum. She will understand what is expected of her and the reasons why she must not do certain things. Her husband and her daughter are very understanding people. Her condition was discussed with them and they will be a big help to her in adjusting once more to her home and social situation.

Foreign Body in the Respiratory Tract

SISTER ST. MARY ELIZABETH, R.H.S.J.

MY NAME IS WAYNE SMITH. I just wanted to ask you a personal question. "Do you allow your children to eat peanuts?" If you do, you shouldn't! Why? Let me tell you.

It was January 24, 1957 — the season when the common cold is a common hazard. I was two years old and was trying to keep away from "Mr. Virus." My brothers and I were being very good — so Daddy seem to think. He brought us home some peanuts — each a nice five-cent bag. We were having grand fun laughing, playing and enjoying them. Suddenly, a peanut "went down the wrong way." I began choking and got quite panicky. I couldn't breathe well at all! Daddy took me by the heels and shook me around a bit and tried slapping me on the back. It did not help a bit! Big tears began running down my cheeks. Then, to top it all off, I got little red spots on my face and neck. Daddy and Mummy were scared and called the doctor. He told them to take me to hospital immediately.

We arrived at the hospital and Mummy carried me up to a little bed. I was breathing a little better now, but I often choked and had to cough a lot. The staff medical doctor came to see me and after an examination diagnosed my case as "blockage with obstruction of the left bronchus and compensatory emphysema on the right side." It sounded awful! He recommended that the staff Ear, Nose and Throat doctor should take over the case.

The diagnosis was confirmed by X-ray. I was kept in hospital and had a bronchoscopy and a tracheotomy performed to get rid of the organic foreign body (peanut) from the main bronchus. There was an acute laryngeal edema as a complication. For both of these operations I received a general anesthetic. The premedication of the bronchoscopy was hyoscine gr. 1/300 followed by demerol 13 mgm.

Hyoscine, one of the belladonna group, is a drug that acts on the autonomic nervous system. One of its main uses is as a preanesthetic agent. It quiets the patient, allays fear and apprehension, reduces shock; but its most important use in my case was the fact that it checks excessive secretions — particularly those of the salivary glands. It is usually administered hypodermically but in the case of a child is given intramuscularly.

Demerol is a drug acting on the central nervous system. It is a synthetic substitute for morphine. It is a potent analgesic, does not have untoward effects and is thus preferred to morphia. It is particularly useful to relieve spasms of the smooth muscles such as are found in the bronchial tubes. The usual dosage is 75-100 mgm. — child's dosage 13 mgm. Because I had severe dyspnea, before the second operation I received only hyoscine.

Ether was administered as the general anesthetic. It is a clear, colorless liquid that results from the action of sulphuric acid on oxygen. It causes a progressive depression of the central nervous system, beginning with the highest intellectual centres and progressing to muscle relaxation, finally eliminating even the reflexes. Ether makes the heart beat faster at first. Then it becomes slower

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Sister St. Mary Elizabeth is a first year student in St. Joseph's School of Nursing, Hotel Dieu Hospital, Kingston, Ont. She received honorable mention.

and weaker as anesthesia deepens. It produces peripheral vasodilation. It may be irritating to the kidneys causing post-operative retention. It is administered by mask inhalator with oxygen. It is generally given because it affords simple relaxation of the whole patient.

As you can see — that lost peanut caused me quite a lot of trouble!

History

Wayne is the fourth in a family of five boys all of whom appeared to be well brought up and very fond of their parents and each other. The father was a rather poor provider, losing his jobs frequently. Despite their financial difficulties. the children were neatly dressed. Unhappily, John the second son, was also in hospital suffering from rheumatic fever at the same time. This double hospitalization came at a very bad time for the family's Blue Cross coverage had lapsed the month before. None of the worry over money matters touched either of the children though it brought new lines to their parents' faces. The mother was a valiant little person who kept the children happy and loving under the great stress that pressed upon the family.

Wayne had been a normal baby, born at full term weighing six pounds, two ounces. He walked at nine months and began talking just after his first birthday. He had had no previous admissions to hospital nor had he been a victim of any of the "children's diseases." On admission to hospital he appeared healthy, except for his accident.

Signs, Symptoms and Anatomy

The trachea or windpipe is a tube about four and a half to five centimeters long, extending from the larynx, through the midline of the neck into the thorax where it divides into the right and left bronchi. Its walls are stiff and rigid containing sixteen to twenty "C"-shaped cartilages which prevent collapse or closure of the trachea. Smooth muscle fibers form the posterior portion. The tube is lined with ciliated epithelium. The blood supply is derived from the subclavian artery; the nerve supply from the vagus nerve. The trachea divides in a line with the juncture of the manubrium and the body of the sternum into two primary bronchi. The bronchi follow an oblique course to the hilus of the lung, where they branch. The right primary bronchus is more vertical, shorter and wider than the left.

When a patient is admitted, careful observation and examination is a joint obligation of the medical team as a whole. Wayne was coughing considerably — a choking, unproductive cough. His skin was pale, not cyanotic; eyes watery. Small pinpoint red spots which did not disappear under pressure were apparent on face and neck. These purpurae or petechiae occur as a result of vascular rupture permitting leakage of blood into the subcutaneous tissue. They resulted in this case from the extremely forceful coughing spasms causing lesions in the superficial capillaries of the face, neck and chest.

He was febrile with a temperature of 103.8° per rectum. (Normal 99.8° "R"). The pulse was about 100 beats per minute and regular (115-100 per min. is considered normal for two-year-olds). Respirations were 40 per minute (normal 25 per min.) and were intermittent with choking, unproductive coughing spasms.

His chest on examination by the interne was reported as follows:

> Inspection — pale no cyanosis
>
> Palpation — diminished excursion on the left
>
> Percussion — no dullness
>
> Auscultation — Left chest clear with diminished breath sounds. Right chest — loud breath sounds with râles and rhonchies which are coarse, dry, abnormal respiratory sounds heard in the bronchial tubes.
>
> There were no abnormalities found in any other part of the body.

Laboratory tests revealed a white blood cell count of 22,150 per cu. mm. as compared with the normal level of 5-9000 per cu. mm. Hemoglobin was down — *72%* — indicating a slight anemia. Examination of the red blood cells showed that there was inequality in the size of the cells. Urinalysis was normal excepting for the presence of acetone bodies, probably directly related to the level of the body temperature.

X-ray. The report of X-ray and

fluoroscopic examination of the chest stated:

> There is intermittent obstruction in the left main stem bronchus which must be occluding the main bronchus itself on the left, but is not apparently solidly lodged for it changes between films and during fluoroscopy.

Bronchoscopy. This is an examination of the interior of the trachea and bronchi with a bronchoscope, a rigid, hollow, illuminated tube making possible direct inspection of these passages. Using this piece of apparatus the doctor seeks to determine if there is:

1. Foreign body in the bronchus
2. Any congenital abnormality of the bronchus
3. Inflammatory bronchial stenosis
4. Detection of lung portions involved in disease.

The bronchoscope promotes drainage and aeration of lungs by clearing passages of exudate in some bronchial conditions. In this case it was done to determine whether or not a foreign body was lodged in the left bronchus. A general anesthetic is always administered and the upper air passages are thoroughly cocainized. The patient is put in the Boyce's position. The tube is inserted and reaches the bifurcation of the trachea. Smaller tubes are inserted to enter the bronchus. With the distal light of the bronchoscope and help of the previous X-rays, the foreign body is located and can be removed by the manipulation of the bronchoscope, as was done. The foreign body was removed in several pieces.

Following the bronchoscopy, Wayne was returned to his room immediately and was put in a croupette, a device whereby cooled, moistened oxygen is administered to the child in a tent. His condition appeared quite good, except for an occasional harsh cough. He was soon able to take fluids by mouth. About three hours later severe dyspnea developed — followed by a substernal and subclavicular retraction of the right chest. During the night his pulse and respirations became rapid — his body cold and clammy. Dyspnea increased with frequent "hooting" sounds and coughs. Towards early morning he became extremely restless and appeared to be in great distress. A tracheotomy was inevitable if the child's life was to be saved. Glottic edema was impairing respirations.

Preoperative Preparation

Before any operation, and especially with children, it is important to avoid all emotional complications. Generally speaking, parents and doctors should be encouraged to introduce children to the hospital previous to admission by means of games, pictures. In this way the child will already be somewhat oriented and thus cooperative with both doctors and nurses. It is also necessary to remember that honesty is the best policy. Evasion breeds anxiety. Pointing out the rapid progress of other children also encourages the child to settle down quietly. The "hero" image appeals to children as does the desire to please mom and dad.

In Wayne's case, surgery was an emergency. Apprehension was not so much a problem with the two-year-old child in distress as it was with the worried mother and father. Both parents appeared quite uncooperative at first and only after they were convinced that the child's life was in grave danger, would they consent to surgery. It took a lot of reassurance and almost severity on the part of both doctor and nurse to gain their confidence and permission. But the dyspnea and the laryngeal stridor proved the turning point. The parents consented to the surgery — we hoped for success!

Preoperative physical fitness is an important factor in reducing the mortality rate and in guarding against later complications. Generally speaking, the following are essential factors for consideration.

1. *Nutritious diet* with special care to the administration of Vitamin K (counteracts bleeding tendencies) and Vitamin C (promotes good wound healing).
2. *Administration of antibiotics* (a) as prophylaxis; (b) to combat infection. In this case Dicrysticin amp. I was a "stat" order. Dicrysticin is an antibiotic containing 300,000 units Procaine Penicillin G. plus 100,000 U. Crystalline Potassium Penicillin G., plus Dihydrostreptomycin sulfate and Streptomycin sulfate. It combats gram negative and gram positive organisms; used as prophylaxis

before and after surgery and in mixed infections in the mediastinum and other body areas. It is given intramuscularly.

3. *Fluid balance* must be maintained. This is a nursing care item of importance especially in children. If severe diarrhea or vomiting precedes surgery the doctor will probably use intravenous therapy.

4. If the *hemoglobin* is low — iron therapy should be given or whole blood transfusions if severe anemia is present. Urinalysis should be done to assure absence of glycosuria and acetonuria.

5. The *temperature* elevation should be reduced by administering antibiotics, sulfa drugs or alcohol sponges. In this case antibiotic therapy was used.

6. *Enemata* and laxatives are given as ordered.

7. *Rest* is essential for the preoperative patient, benefitting both mental and physical faculties. Sedatives should be administered. In this case Somnos drams ii was ordered q.4 h. p.r.n. Somnos is a trade name for an elixir form of chloral hydrate, each ounce containing 25 grains of hydrate of trichloraldehyde. It is a drug affecting the central nervous system. It depresses the cerebrum giving a somewhat natural sleep in a short time. It is used as a sedative and a hypnotic. Wayne was given this elixir.

8. A *history* and *physical* examination by the interne are essential before surgery.

9. *Skin preparation*: The area prepared is the neck, under the chin and the upper chest.

10. The *preoperative medication* is administered. It quiets the patient, lowers metabolic activity rendering him more susceptible to the anesthetic; provides mild analgesic effect; requires administration of less anesthetic following it. The type of medication depends on three factors: 1. Age of patient; 2. preoperative condition; 3. type of operation. For the two-year-old boy, having great respiratory difficulty and requiring an emergency tracheotomy, hyoscine gr. 1/300 was given intramuscularly a half-hour prior to surgery.

11. The patient should be bathed before surgery and be wearing a hospital gown. Have the patient void before going to the operating room if possible. With Wayne, we checked for dry gown and diapers. Have the chart in order with extra sheets if needed. In moving a patient to the operating theatre preventing heat loss is an important prophylactic measure. Room temperature should be kept at 60-70°. T.R.P. and blood pressure should be taken before operation as a guide to the condition of the patient during anesthesia.

Post-*tracheotomy*. An incision is made into the trachea to allow the insertion of a tube to facilitate breathing. The postoperative nursing care of the patient is centred on maintaining this artificial air passage free from obstruction and excess secretion. The tube is fixed in the incision and is secured on the outside by tapes tied around the patient's neck. Gauze dressings are placed between the plate and the neck. The patient should be returned immediately to his room which is well humidified.

Wayne was put into a croupette running at 5-6 litres. He was put in low Fowler's position as soon as possible and kept warm. A suction apparatus was on hand — as well as a tray with equipment for caring for the tracheotomy setup. The tube consists of a double cannula having an inner removable portion longer than the outer one and which is held in place by a latch. This is the portion for which the nurse is responsible. The tray of equipment should consist of: a small brush; gauze dressings; glass of water; forceps, no. 12 catheter and connecting tube.

After Wayne came back to his room his arms were restrained to prevent him pulling at his dressings or the tube. Temperature was 101°; pulse regular, 110 per minute; respirations 45-50 per minute, shallow, broken by spells of coughing. He expelled large quantities of mucus through the cannula. It was necessary to apply frequent suction. This is done by attaching the catheter to the suction tubing and using very low pressure. The catheter is clamped off between the fingers, inserted into the tracheotomy tube a short distance, the finger pressure released and the catheter rotated gently. This is done quickly and then the catheter is removed and clear water suctioned through to cleanse it. The procedure is repeated until the trachea is clear of mucus.

Wayne's color was good. Respirations and pulse were checked every 15 minutes. He was only beginning to react on return to his room.

During the first few hours Wayne was in need of constant attention: It was essential to maintain a clear breathing passage constantly. His life was in the nurses' hands. It was also important to keep him clean and dry, to note any difficulties or untoward changes in his condition, and to watch over the croucondition, and to watch over the croupette therapy.

During the next few hours respirations became gradually easier and deeper. Wayne was soon offered orange juice by mouth. About an hour later he became very restless, coughing a great deal — with the suction offering no relief. He vomited orange liquid emesis. We decided to clean the inner tube as a possible solution. This was done by simply unlocking the inner tube, cleansing it through with water, drawing a small piece of gauze through it, or a small brush, and then reinserting the tube. Care must be taken that it is dry and locked securely in place — also, that clean gauze is protecting the surrounding skin from exudate. Respiratory difficulties lessened and he began dozing for short intervals.

About eight hours postoperatively he voided. At the end of twelve hours his breathing was much improved; he was retaining liquids satisfactorily. The mucous discharge and exudate were much lessened. Two days later he was able to get up and the oxygen therapy was discontinued. By then he could take soft bland foods. Despite his "silence" he was very cooperative and played quietly with the other children. It was always our responsibility to anticipate his needs for food and drink and to see when he wanted to go to the bathroom; also to keep him clean and dry. Like all children he loved attention.

Five days after admission Wayne began to speak when his parents came to visit him. The next day he was able to speak and cry. Two days later tape was put over the cannula opening. This was successful so the cannula was removed, and the incision covered with a small dressing. Fifteen days after admission he was discharged, after the tracheal area was cauterized with silver nitrate sticks by the doctor.

Nursing Notes

During Wayne's convalescence it was the nurse's responsibility to maintain the body fluid balance by offering liquids to the child — and when he was able, to encourage him to eat. It was also her responsibility to see that constipation was not a complication. This latter was overcome by the administration of a glycerin suppository which acted as a laxative.

The nurse was also responsible for the croupette. She must see that the flow of oxygen is regulated as necessary, and be alert as the tank empties to have it replaced. Also, she must see that the water attachment contains sufficient distilled water. Thirdly she must see that the ice compartment has sufficient ice to give a cool flow of oxygen.

Diet is an important part of the care. Wayne was given fluids only, at first. This was changed to soft bland foods like rice, ice cream, banana and cream of wheat. He was kept on a soft diet for seven days postoperatively then given regular meals.

Play therapy is important in a child's care. When he was able to be up and moving around we encouraged Wayne to play with cards, balloons and his cars. He liked attention and was glad to have someone to play with him, but was quite contented and seldom cried. It was the nurse's responsibility to see that he had something to play with — something that was not hazardous to a two-year-old child.

Teaching the Parents

The prevention of this type of accident is of utmost importance. The teaching and rehabilitation of both parents and child consist of pointing out the danger of a child putting coins, buttons, pins, etc. into his mouth. Open safety pins should never be stuck into a pillow beside a baby. Toys should be inspected frequently for loose parts. Small children should not be given foods which can be easily aspirated such as nuts, popcorn, small hard candies. The child should be warned not to run or laugh with food in his mouth. He must learn to masticate thoroughly before swallowing.

The parents should realize that it is their responsibility to administer medications at home and to visit the doctor's office as ordered. In this case Bicillin 300 was ordered to be given twice

daily. The child was to be taken to the doctor's office the following week. Bicillin 300 suspension is an antibiotic containing 300,000 I.U. per teaspoonful and prevents infection as well as counteracting any that may be present.

The prognosis is for a complete cure with no complications.

What I Learned

1. The need of care and observation of children at all times.
2. The danger when small objects are left within reach.
3. The typical quick onset of illness and rapid recovery seen in children.
4. The care of a tracheotomy.
5. Parent's role during illness.

Acute Glaucoma

Doreen de Souza

Introduction

How many of us today shudder at the dreaded word glaucoma? To how many people is this word synonymous with blindness!

Mrs. West was admitted to the hospital by stretcher in October, 1957. From the expression on her face, the small, slight woman huddled on the bed, apparently was suffering a great deal of pain. She seemed very, very old and depressed. Mrs. West had had surgery on her right eye some time previously and was only able to see very bright light. Her left eye was a prosthesis. Her first request was for medication to relieve her pain. She was given acetophen compound and codeine that the doctor had ordered q.4 h. p.r.n. for pain. After she had taken the tablet she seemed less tense and talked freely.

Social Background

Mrs. West was a 64-year-old Canadian. She has one son who is employed with the Canadian Broadcasting Corporation as a news editor. He is also ranked as one of America's 10 best novelists. Since the son is unmarried, he lives with his mother, and she takes care of the home.

Mrs. West was accustomed to helping her son by reading and criticizing his articles and novels before they were published. Her hospitalization did not create any domestic problems as her son secured help. There seemed to be no financial difficulty since his job is an adequate one and he was able to meet the hospital expenses. The home environment was apparently a happy and comfortable one.

Mrs. West seemed to be in fairly good physical health. Her skin texture and color were good. There was no edema or dehydration of the extremities. She had a slight paralysis of her right side.

Her right eye was very inflamed. The cornea seemed hazy and at this stage she was only able to distinguish between very bright light and darkness. She complained constantly of headache.

Mrs. West's attitude towards her illness was not a very healthy one at first. She could not accept the fact that she was almost blind. She was depressed and rather bitter. After a few weeks had passed, however, she became reconciled to her condition. She was always very cooperative but very nervous. She had some difficulty in adjusting physically to the fact that she could no longer see, but the nurses were successful in teaching her to help herself to some extent. She soon appreciated the fact that others would be able to accept her disability only if she herself adjusted to it.

Medical History

After many discussions with Mrs. West certain very interesting details regarding her medical history were learned. Four years prior to this admission, she had lost her left eye from

Miss de Souza, an intermediate student at St. Mary's Hospital, Montreal, was awarded an Honorable Mention book prize for this study in the recent Macmillan Award competition.

glaucoma. The course of her illness at that time exhibited all the symptoms of impaired peripheral vision, cloudy vision, and irritation. The symptoms appeared gradually and insidiously. In fact, they developed so gradually that Mrs. West did not realize that her eye was becoming blind until the condition was well advanced. Her doctor diagnosed chronic glaucoma. He suggested complete removal of the eyeball and the use of a prosthesis, which was done.

In 1955 she suffered cerebrovascular accident and was hospitalized for two months. She felt that the stroke was a result of her frequent trips to the convalescent home "day and night" to care for her invalid husband. After this, she was slightly paralyzed on the right side and dragged her right foot.

She had suffered an attack of cystitis and a prolapsed uterus a number of years previously. Both of these conditions showed symptoms during this hospitalization and were adequately treated.

Mrs. West complained also of gastrointestinal disturbance. This was investigated by x-ray. No abnormalities were found, but the patient was given medication to treat indigestion and constipation.

In relation to her present illness, she had suffered from headaches regularly since the removal of her left eye. The headaches were relieved by rest, and would disappear completely for a period of time. Three to four weeks before her most recent hospitalization, she began to experience more frequent headaches that steadily increased in intensity and duration. On the evening of her admission the pain in her head was agonizing and she suffered severe pain in her right eye. A quick physical examination revealed an inflamed right eye with a very narrow pupil and no reaction to light. The tension was tested with a tonometer and found to be 60.

Her reflexes were normal with marked difficulty of movement on the right side. There was no murmur or thrill of the heart, and the apex beat was normal. No other physical defects, congenital or otherwise, were shown. Mrs. West was too ill to be questioned about her childhood diseases. Her blood pressure was taken and was 220/120. All other vital signs were within normal range. The final diagnosis was "acute glaucoma and hypertension."

Glaucoma is a disease characterized by increased tension or pressure within the eye. It occurs usually, in individuals over 40 years of age. Normally, fluid that enters the eye is balanced by that which leaves the eye. In glaucoma more fluid is secreted than is absorbed.

There are two main types of glaucoma — primary and chronic. The etiology of primary glaucoma is unknown. It is often associated with endocrine imbalance, emotional upset, allergies, and vasomotor disturbances. The last mentioned cause suggests that Mrs. West's hypertension could have had great significance.

Chronic glaucoma, on the other hand, is usually a complication of some other disease of the eye. The imbalance of fluids in the eye takes place gradually. Symptoms are slight and gradual. When it occurs rapidly, however, severe, intense pain results from pressure on the optic nerve. The diagnosis is usually made by a tonometer or pressure may be noted with the fingers.

Chronic glaucoma, if detected early, is treated with drugs that contract the pupil, draw the iris away from the cornea, and promote drainage of the fluid into the Canal of Schlemm. In the acute stage, surgical treatment is employed. An iridectomy or iridencleisis may be done. These have the same effects as drug therapy. If untreated, glaucoma leads to blindness.

The prognosis for chronic glaucoma is usually very good if detected early enough. The condition may be arrested at the stage it is discovered, but the impairment in vision can not be overcome.

Acute glaucoma has a very poor prognosis. Vision is usually either lost or very severely affected. Even with surgical treatment, such as that employed in Mrs. West's case, the pressure and pain sometimes persist.

Therapy

Due to her acute pain, Mrs. West was treated as an emergency admission and posted for immediate surgery. An analgesic compound was ordered and given. Little or no physical preparation was necessary, but psychological pre-

paration was very important. As the nurse prepared Mrs. West for the operating room, she told her what to expect after surgery.

She explained that Mrs. West's eye would be covered for approximately 48 hours. This would help to reduce movement of the eyeball and to facilitate the healing process. The nurse stressed the importance of lying quietly in bed. The patient was shown how to use her call light and was assured that a nurse would be nearby at all times. Mrs. West went to the operating room one hour after admission, suffering pain, but much more relaxed and less apprehensive.

The surgical treatment was an iridencleisis.

> Under local anesthesia and retrobulbar injection with novocaine, a conjunctival flap, 5 mm. wide, was dissected down to the limbus. The anterior chamber was entered with the keratone and the iris presented. The iris was seized in the middle and pulled forward. It was then cut in the centre, and both borders of the iris were tucked into lateral angles of the incision. The flap was closed with chromic catgut.

Mrs. West's immediate postoperative care included placing her in a dorsal position and putting sides on her bed. The bed sides were explained and the need for them stressed. She was told not to touch her dressings and reminded of the instructions given previously — especially that she was to lie very still.

Mrs. West did not complain of pain during the evening. At bedtime she was given warm milk, Seconal gr. 1½ and Largactil 25 mg. to assure maximum rest. The head of the bed was raised slightly, and the patient was turned on the unaffected side.

Mrs. West suffered very little discomfort immediately postoperatively. She progressed from a liquid diet to a soft one and ate well. Mouth care was given frequently since her teeth could not be brushed. At bedtime a sedative, Tuinal gr. III, was given to assure an adequate amount of sleep. The dressings were changed for the first time on the third postoperative day. The patient was told that this would be done and that it was not a painful procedure.

The lighting was arranged so that there was no glare. The doctor cleansed the eye, examined it briefly, then covered it with gauze moistened with a solution of warm saline. The gauze was then covered with a cotton pad taped to the cheek and the mask reapplied. After this the dressings were changed every day. Atropine one drop, was ordered followed by 10% neosynephrine, one drop. Both these drugs dilate the pupil, but neosynephrine is short acting, while the effects of atropine are longer.

At this point in her recovery there were no untoward symptoms. Mrs. West's fluid and electrolyte balance were normal. She was voiding well. As her diet was liquid, soft, and then bland, there was a decrease in bowel function. On the fifth postoperative day she was given a mild cathartic of milk of magnesia, one ounce, with cascara, 10 drops, to avoid any straining on defecation.

Serpasil and Apresoline were the antihypertensive drugs used. The former lowers blood pressure through its inhibitory action on the sympathetic system. The latter inactivates pressor substances found in the blood. Mrs. West's blood pressure was reduced to 150/90.

Fourteen days after the operation, when the chromic catgut used for suturing had absorbed, the dressings were removed. The shades were drawn and the lighting arranged. Mrs. West looked about her and stated that she could only see the top of the nurse's head, and that there seemed to be a very bright light in her eye. The following day she saw only the bright light. After this she began to complain of headaches. Acetophen compound with codeine was ordered q.4 h. p.r.n. for pain and from this she obtained relief.

Mrs. West again became apprehensive and depressed. She complained continuously of very severe headache and brightness in her eye. The intraoccular pressure returned and there was hypertension at intervals. Diamox, a diuretic 250 mg., was given to maintain kidney function. Sodium amytal gr. 3¾ was ordered to be given if the systolic blood pressure was above 200. To treat her increasingly painful headaches novocaine and absolute alcohol were injected into

the retrobulbar area to produce partial paralysis of the optic nerve and reduce the pain resulting from nerve pressure.

The patient was very upset when the doctor told her this was to be done. She questioned him as to whether this would destroy her chances of ever seeing again. The doctor explained that the purpose of the injections was to relieve the severity of her headaches, and that whatever sight there was would suffer very little impairment. This treatment resulted in markedly lessened severity of headaches and disappearance of the sensation of bright light in the eye. Ice compresses were applied to relieve the inflammation of the cornea.

Phenobarbital gr. ¼ was given b.i.d. to promote muscular relaxation and Largactil was given for its tranquilizing effect. A sedative was always given at bedtime. The diet was changed to a soft house tray and Mrs. West ate well.

Efficient nursing care played a very important part. The nurses were kind and sympathetic but never pitying. Since Mrs. West was in a semi-private room, her roommate was instructed not to be overly sympathetic and to avoid expressions of pity. Her tray and bedside table were arranged in the same manner every day so that she could reach easily for articles. The door was left either completely open or shut depending on the patient's wishes. The nurses always announced their presence and what they were doing.

Other general rules of good nursing were followed during the course of her illness. Back care was given frequently to prevent decubitus ulcers. A footboard was used to remove the pressure of bedding from her feet.

Four weeks after surgery, Mrs. West was allowed to sit in her chair and to take short walks. An effort was made to help her overcome her feeling of helplessness and awkwardness. Each day when she got out of bed, she was encouraged to become familiar with her room by touching the furniture and sensing its position. Each day the nurses made sure that the furniture was in the same place. When walking with her in the hospital corridor the nurse always described where they were and the activities about them. Mrs. West liked to be told of things around her and showed an interest in everyday occurrences such as the weather.

Her personal appearance is of significance to any patient and even more so in the patient unable to see. Mrs. West was always encouraged to help as much as possible with her personal care. She was often complimented on her appearance by the nurses.

Her former urological and gynecological conditions showed fresh symptoms for which treatment was given.

Gantrisin, a sulfonamide urinary antiseptic was given to relieve urological symptoms. For gastric distress, amphogel was given since this neutralizes acidity. Regulex was given to promote regular easy bowel movements and saline enemas were ordered p.r.n. for constipation. Warm lactic acid douches and a Nystatin vaginal suppository were given at bedtime to relieve symptoms induced by the uterine prolapse.

Mrs. West appeared to adjust well to hospital environment. She learned to view illness objectively, to a certain extent, and became most concerned about one of her acutely ill roommates. She was very cooperative in the matter of taking medications and accepting treatments. Her progress was not very rapid, and so she was quite proud of any achievement, no matter how slight. The nurses gained her confidence and she always discussed problems freely with them. Her apprehensive, tense manner gradually disappeared.

Health Teaching

Mrs. West's health teaching consisted of trying to help her to accept her disability. She was taught that although she would be dependent on someone for the rest of her life, still she would not be an invalid. It was impressed upon her that with help, she could do much for herself.

She was reminded of the importance of avoiding emotional upsets. Tight clothing should not be worn. Regular bowel habits should be developed to avoid strain. The importance of moderate forms of exercise and the immediate treatment of any infection was stressed. Frequent visits to the eye clinic were

suggested. Mrs. West was told to leave her eye exposed as much as possible. She showed considerable interest in these instructions, and as the teaching was timely and gradual, she responded well.

Conclusion

This patient has shown remarkable ability in adjusting to and accepting a condition that has caused severe emotional reaction in many individuals. To prevent further difficulty she must observe the suggested precautions carefully and report conscientiously for follow-up examinations.

Her illness was a classic example of acute glaucoma and its treatment which, unfortunately, often shows poor results.

A Nutrition Experiment

Ann Augusta

"Experience is the best teacher." The accuracy of this statement was proven in our Nursing Arts laboratory recently, when ten preclinical students took part in a project to discover, by actual experience, just what feeding helpless patients really involves.

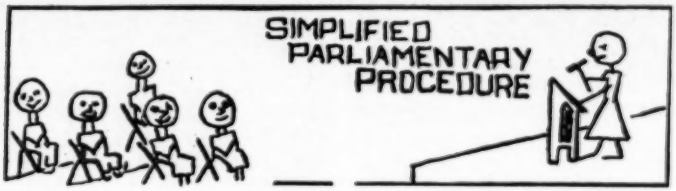
We were given the opportunity to act as both patients and nurses. This method of study was based on "empathy" whereby, in an imaginative projection of one's consciousness into another human being, a sympathetic understanding of the other person can be evolved. To achieve this we were given an insight into the problem of efficient and competent feeding, not only from the nurses' point of view but also that of the patient.

The actual procedure was authentic. Students who usually received their lunch in the cafeteria were fed from trays obtained from the hospital kitchen. We, as nurses, strove to see our patient not as a classmate but as a helpless individual whose enjoyment of and benefit from the meal depended

(Continued on page 654)

Miss Augusta is a student at Edmonton General Hospital, Edmonton, Alberta.

Learning through experience.



VII Incidental Main Motions

As noted previously, any one of these incidental motions may be made at any time during business discussions excepting when a privileged main motion is being considered. Each is dealt with as it arises since most of them have a definite bearing on the rights and privileges of members.

Point of Order

As has been learned in this series there are many definite rules governing discussions during a business session, such as which motions are debatable, the sequence in which motions may be made, the relevance of an amendment. In addition, motions limiting the length of time or the number of times an individual may speak may be made. Occasionally, an over-enthusiastic non-member may wish to take part in discussion; a non-voting delegate may move or second a motion, both of which are out of order.

Should the chairman overlook any of the rules of parliamentary procedure or permit infractions such as are suggested above, any member may call attention to this violation or omission or error by "rising to a point of order." This motion may also be used to obtain an explanation regarding the rules.

Member (standing, speaks without waiting for recognition) Madam Chairman, I rise to a point of order. (No seconder is required since this is not a true motion.)

Chair What is your point of order?

Member My point of order is that the amendment just proposed has been made after we have been discussing the referral of this matter to a special committee.

Chair Your point is well taken. The amendment is out of order.

A point of order should be raised as soon as an error is made. It cannot be used to change decisions later if it went unnoticed at the time, excepting where such decisions are in conflict with the constitution or bylaws. The point of order must be raised even though someone is actually speaking. No further discussion is permitted until the chairman has made a decision regarding the validity of the point of order.

The chairman may wish to have the meeting make the decision in a complicated situation. For example, she might say:

Those who favor permitting the member to speak to this motion for the fourth time say "Aye." Those who are not in favor say "Nay."

Appeal from the Decision of the Chair

The object of such an appeal is to permit a member who may feel that a decision was incorrectly or unfairly made, particularly in regard to a point of order, to state her case. The appeal must be made immediately after the decision is announced, even though it means interrupting another speaker. The motion is made thus:

Member Madam Chairman, I appeal from the decision of the chair.

Chairman The decision of the chair has been appealed. Will the member please state the grounds for the appeal.

Following this statement, the chairman may give her reasons for making the decision or she may ask for a seconder of the motion so that it may be debated by the meeting. The secretary would enter the motion in her minutes and indicate "chair's decision sustained" (or "overruled").

To Withdraw a Motion

One of the most common infractions of parliamentary law occurs when, after a motion has been stated by the chair

and is under discussion, the proposer of the motion decides she should never have made it and says "I want to withdraw my motion." An uninformed chairman may benevolently agree, without asking if there is any objection to this withdrawal and discussion stops.

Before a motion has been thrown open for discussion by the chair, the proposer is free to change the wording or withdraw her motion if she chooses. No seconder is required as this is a personal wish. The chair or any other member may suggest that the mover withdraw the motion. No mention of it is made in the minutes.

After a motion has been stated and discussion has started, the proposer may still request that her motion be withdrawn but the chairman *must* give the assembly an opportunity to voice any objections. If there are no objections, the motion ceases to exist. If even one voice is raised in objection, the question of withdrawal has to be put to a vote. The proposer or any other member may move "that permission be given to withdraw the motion." This motion requires a seconder, is not debatable, and is decided by a majority vote. If withdrawal is approved, no mention of the original motion appears in the minutes.

Objection to Consideration

Immediately following the presentation of a main motion, a motion of objection may be made if a member believe that discussion of the business presented may prove embarrassing, not be worthwhile or that the time is not opportune. Since no seconder is required for an objection, the chairman calls for an immediate vote. The motion of objection to consideration requires a two-thirds negative vote to prevent continuation of the discussion on the main motion since it infringes on the rights of those who have introduced the main motion in the first place. To avoid any possible error in counting the votes it is customary to have the members stand to signify their approval or disapproval.

Nominations

Whether it is for annual elections or to name the persons to form a committee, every organization, at one time or another, makes nominations. Even though the bylaws may provide for a Nominating Committee to present a slate, it is customary for the chairman to call for nominations when the report is presented.

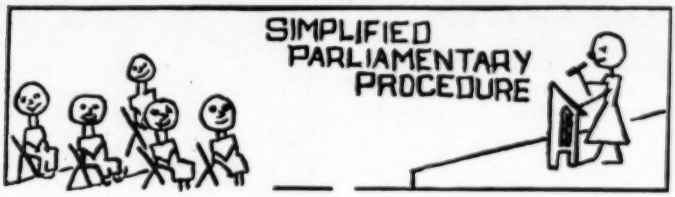
Unless the bylaws specifically stipulate it, a nomination does not require a seconder, although seconding may be permitted if someone wishes to endorse a particular candidate. As nominations are made from the floor, the chairman should repeat the names, the secretary records them in her notebook and, frequently, another member writes them on a blackboard.

When it appears that there are no further nominations, the chairman has the choice of declaring nominations closed or calling for a motion to close them. After such a motion has been seconded, it requires only a majority vote to be carried. However, closing nominations does not mean that where only one name is presented for each office, the nominee is automatically elected. Unless the bylaws state that where only one name is presented for any office the nominee is elected by acclamation, it is usual for the chairman to request the secretary to "cast one ballot."

Voting

Every active member of an organization has an inherent right to participate in the decisions made at meetings. This right is exercised as she votes. Though there are several ways in which members may vote, the goal is the same in each — to determine the will of the majority. Any one of the following methods may be used:

1. *Voice vote:* The chairman asks those in favor to say "Aye," contrary "Nay." The volume of sound is used to gauge the result.
2. *Show of hands:* This method permits a count of those for and against, to be made.
3. *Standing:* First those in favor, then those opposed are asked to rise so that a more accurate count may be made or estimated.
4. *Roll call:* If it is desired to record the vote of each member, the vote is spoken as the names are called by the secretary.
5. *Ballot:* This method is most frequently used in elections or in voting upon



VII Incidental Main Motions

As noted previously, any one of these incidental motions may be made at any time during business discussions excepting when a privileged main motion is being considered. Each is dealt with as it arises since most of them have a definite bearing on the rights and privileges of members.

Point of Order

As has been learned in this series there are many definite rules governing discussions during a business session, such as which motions are debatable, the sequence in which motions may be made, the relevance of an amendment. In addition, motions limiting the length of time or the number of times an individual may speak may be made. Occasionally, an over-enthusiastic non-member may wish to take part in discussion; a non-voting delegate may move or second a motion, both of which are out of order.

Should the chairman overlook any of the rules of parliamentary procedure or permit infractions such as are suggested above, any member may call attention to this violation or omission or error by "rising to a point of order." This motion may also be used to obtain an explanation regarding the rules.

Member (standing, speaks without waiting for recognition) Madam Chairman, I rise to a point of order. (No seconder is required since this is not a true motion.)

Chair What is your point of order?

Member My point of order is that the amendment just proposed has been made after we have been discussing the referral of this matter to a special committee.

Chair Your point is well taken. The amendment is out of order.

A point of order should be raised as soon as an error is made. It cannot be used to change decisions later if it went unnoticed at the time, excepting where such decisions are in conflict with the constitution or bylaws. The point of order must be raised even though someone is actually speaking. No further discussion is permitted until the chairman has made a decision regarding the validity of the point of order.

The chairman may wish to have the meeting make the decision in a complicated situation. For example, she might say:

Those who favor permitting the member to speak to this motion for the fourth time say "Aye." Those who are not in favor say "Nay."

Appeal from the Decision of the Chair

The object of such an appeal is to permit a member who may feel that a decision was incorrectly or unfairly made, particularly in regard to a point of order, to state her case. The appeal must be made immediately after the decision is announced, even though it means interrupting another speaker. The motion is made thus:

Member Madam Chairman, I appeal from the decision of the chair.

Chairman The decision of the chair has been appealed. Will the member please state the grounds for the appeal.

Following this statement, the chairman may give her reasons for making the decision or she may ask for a seconder of the motion so that it may be debated by the meeting. The secretary would enter the motion in her minutes and indicate "chair's decision sustained" (or "overruled").

To Withdraw a Motion

One of the most common infractions of parliamentary law occurs when, after a motion has been stated by the chair

and is under discussion, the proposer of the motion decides she should never have made it and says "I want to withdraw my motion." An uninformed chairman may benevolently agree, without asking if there is any objection to this withdrawal and discussion stops.

Before a motion has been thrown open for discussion by the chair, the proposer is free to change the wording or withdraw her motion if she chooses. No seconder is required as this is a personal wish. The chair or any other member may suggest that the mover withdraw the motion. No mention of it is made in the minutes.

After a motion has been stated and discussion has started, the proposer may still request that her motion be withdrawn but the chairman *must* give the assembly an opportunity to voice any objections. If there are no objections, the motion ceases to exist. If even one voice is raised in objection, the question of withdrawal has to be put to a vote. The proposer or any other member may move "that permission be given to withdraw the motion." This motion requires a seconder, is not debatable, and is decided by a majority vote. If withdrawal is approved, no mention of the original motion appears in the minutes.

Objection to Consideration

Immediately following the presentation of a main motion, a motion of objection may be made if a member believe that discussion of the business presented may prove embarrassing, not be worthwhile or that the time is not opportune. Since no seconder is required for an objection, the chairman calls for an immediate vote. The motion of objection to consideration requires a two-thirds negative vote to prevent continuation of the discussion on the main motion since it infringes on the rights of those who have introduced the main motion in the first place. To avoid any possible error in counting the votes it is customary to have the members stand to signify their approval or disapproval.

Nominations

Whether it is for annual elections or to name the persons to form a committee, every organization, at one time or another, makes nominations. Even though the bylaws may provide for a Nominating Committee to present a slate, it is customary for the chairman to call for nominations when the report is presented.

Unless the bylaws specifically stipulate it, a nomination does not require a seconder, although seconding may be permitted if someone wishes to endorse a particular candidate. As nominations are made from the floor, the chairman should repeat the names, the secretary records them in her notebook and, frequently, another member writes them on a blackboard.

When it appears that there are no further nominations, the chairman has the choice of declaring nominations closed or calling for a motion to close them. After such a motion has been seconded, it requires only a majority vote to be carried. However, closing nominations does not mean that where only one name is presented for each office, the nominee is automatically elected. Unless the bylaws state that where only one name is presented for any office the nominee is elected by acclamation, it is usual for the chairman to request the secretary to "cast one ballot."

Voting

Every active member of an organization has an inherent right to participate in the decisions made at meetings. This right is exercised as she votes. Though there are several ways in which members may vote, the goal is the same in each — to determine the will of the majority. Any one of the following methods may be used:

1. *Voice vote:* The chairman asks those in favor to say "Aye," contrary "Nay." The volume of sound is used to gauge the result.
2. *Show of hands:* This method permits a count of those for and against, to be made.
3. *Standing:* First those in favor, then those opposed are asked to rise so that a more accurate count may be made or estimated.
4. *Roll call:* If it is desired to record the vote of each member, the vote is spoken as the names are called by the secretary.
5. *Ballot:* This method is most frequently used in elections or in voting upon

succès auprès des étudiantes.

L'organisation d'un cours de soins à domicile convenant aux étudiantes-infirmières est un besoin urgent. Or la profession infirmière a toujours trouvé des solutions aux problèmes d'actualité. Où sont alors les personnes intéressées qui accepteront de battre les sentiers de l'expérimentation? L'appel est pressant: les étudiantes-infirmières du Canada français réclament ce cours qui les préparera à servir au foyer, selon la tradition de qualité qui caractérise leur profession.

Un Institut sur l'Hygiène Maternelle

Pendant trois jours, les infirmières du Service de Santé de la Ville de Montréal, grâce à l'autorisation du directeur et de l'infirmière en chef, et guidées par Mademoiselle Esther Robertson, infirmière-conseil à la Division de l'Hygiène Maternelle et Infantile au Ministère de la Santé Nationale, ont procédé à la revision systématique de leurs connaissances en la matière. Il existe deux façons très différentes d'évaluer ses connaissances. On peut les évaluer d'après ce que l'on considère comme leur valeur intrinsèque. On peut aussi les évaluer en fonction de leur efficacité en tant que facteurs d'enseignement. En vue d'atteindre ces deux aspects de leur étude, les infirmières ont voulu d'abord se rassurer elles-mêmes par la mise en commun des connaissances acquises, et ensuite, elles ont cherché les moyens de rendre plus efficace les méthodes appliquées, et susceptibles de transmettre avec succès la matière à enseigner.

Il est essentiel que l'oeuvre éducative d'un institut de ce calibre soit placée sous le signe de la collaboration. Ici, il y avait plus. Il y avait l'enthousiasme, il y avait l'exubérance "latine," particulière à la Province de Québec, ce que Mademoiselle Robertson a dû ne pas manquer d'observer.

Avec le succès si évident de l'institut, en vertu même de ce succès, une nouvelle échelle de valeurs s'élabore déjà pour les améliorations futures, car il faut toujours garder présent à l'esprit que les infirmières en général se préoccupent bien plus de leur tâche actuelle que des mérites qu'elles s'acquièrent à la longueur des jours.

Et la preuve, c'est que "Nos mères se portent bien, merci . . ."

— GABRIELLE D. CÔTÉ

(Continued from page 649)

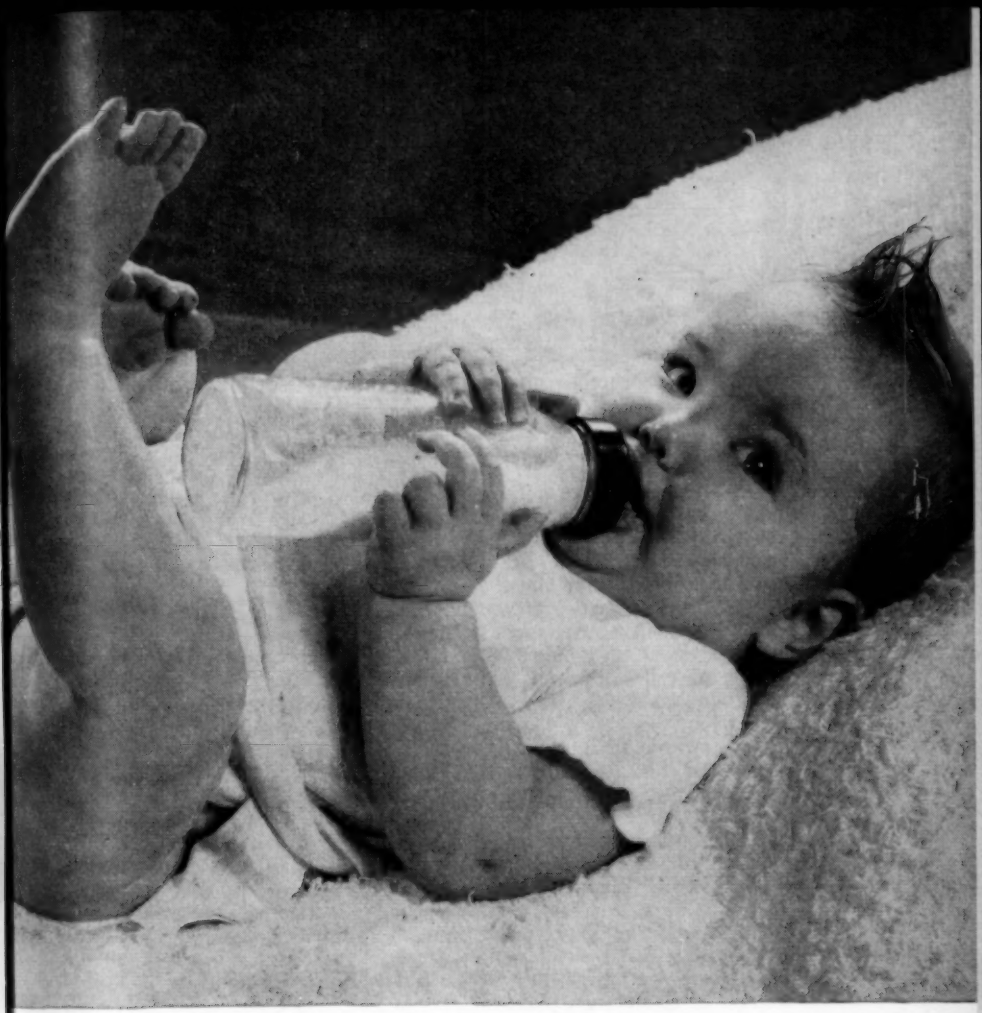
largely on the nurse.

To establish a suitable atmosphere, the student-patients were blindfolded, thus causing them to be more dependent on us, the nurses. Because the patient was unable to see, it was part of the nurse's duty to describe the meal, giving the recipient a pleasing mental picture. This, in all cases, was accomplished effectively.

Following the experiment, we presented a panel which enabled us to share our findings with the whole class. Questions were asked which we who had participated answered, using the information gained from our experiment. Some of the questions of common interest were: "what mental attitude does the patient have towards being fed?"; and "How much should we converse with our patient during the course of the meal?"

We learned that being a helpless patient gives one a feeling of utter dependence, even of some humiliation. In every case the nurse can do much to lessen these feelings simply by being kind and considerate. We learned too, that food loses much of its appeal, and a great deal of the pleasure associated with eating is lost when the patient is unable to see the meal. Deciding that conversation could both aid and hinder a meal, we resolved that when feeding actual patients, we would refrain from continual chatter. From our experience we learned that the enjoyment of the meal for the patient, depends largely on the nurse who must help him accept and bear his undesirable state of dependence. As one student aptly put it, "It is better to give than to receive, even when it comes to our meals."

At the conclusion of the discussion we, as students, felt that we had gained a great deal from our endeavor. We would recommend this method of learning to all students who wish to gain knowledge through experience.



Futurist

His is the expectant view. He's on the lookout for the future perfect. And getting there. He is an S-M-A baby.

His doctor is a futurist too. He prescribes S-M-A knowing the formula most closely resembles mother's milk . . . that it needs no vitamin supplementation . . . that S-M-A builds strong, healthy bodies.

Sound Infant Nutrition
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S-M-A
16 oz. tins

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

CNA Anniversary Spoons

Have you seen the attractive sterling silver coffee spoons bearing the new CNA crest which were available at the 50th Anniversary Meeting in June? The crest is depicted in color and the entire effect is most attractive. If you are starting a collection of coffee spoons here's the place to start. Each nurse will want one, even our collector friends will be interested.

Proceeds from the sale of these spoons will go towards the fund for the Pilot Project for the Evaluation of Schools of Nursing. Cost of spoons is $2.50.

You may place your order by writing to **Canadian Nurses' Association, 270 Laurier Avenue West, Ottawa.**

Institute for Executive Secretaries

Last September, you may have read in this column of an institute planned for executive secretaries and registrars from the ten provincial registered nurses' associations and the CNA which was to have been held in Montreal. Due to the many preparations involved in planning for the first Canadian Conference on Nursing and to the limited staff in National Office at that time, it was agreed to postpone this institute for a year.

During the week of September 15th of this year the institute, sponsored by the CNA will be held at the University of Toronto School of Nursing. Lecturers will include representatives from the legal profession, Canadian Association for Adult Education, business administration, industrial relations, the R.C.M.P. and nurses.

This conference, the first of a series, should prove to be extremely helpful to the nurses who have the responsibility of carrying on the very complex functions of our professional associations.

Eleventh World Health Assembly

Miss **Alice Girard,** our new President, attended the Eleventh World Health Assembly held in Minneapolis in May.

Together with the following nurses, Miss Girard attended the meeting as an I.C.N. representative: Miss Liselotte Felber, Austria, Srta. Carmen Bendoyro Mas, Cuba, Miss Eila Kauppinen, Finland, Miss Myrtle Webb-Johnson, Great Britain, Miss Hermien Coehoorn, Netherlands, Miss Leah Wilner, Israel, Miss Matsu Kano, Japan, Mrs. Janet Buckle, Liberia, Mrs. Rosario Perpinan, Philippines.

CNA is Your Association

Each registrant at the June convention received a copy of *CNA is Your Association*. This newly revised copy is available in both French and English free of charge from National Office. Designed to interpret CNA and its activities to members, prospective members and co-workers — it is an easily read, compact, interesting booklet.

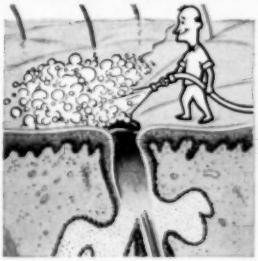
"The Hands That Heal"

In the June issue in this column the above-named film, prepared by the Department of Citizenship and Immigration, was described.

We are now pleased to tell you that the Department has kindly given a copy of the film to the CNA. We shall be glad to loan this copy to nurses wishing to use it in student counselling.

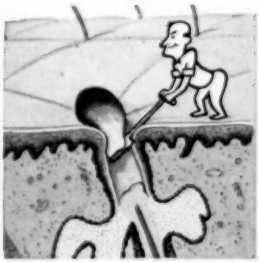
IN ACNE

Fostex® degreases the skin and helps remove blackheads



Fostex contains a combination of surface active agents (Sebulytic*) which:

◂ Completely emulsify excess oil so that it is quickly washed off the skin.



◂ Penetrate and soften comedones, unblocking the pores and facilitating removal of sebum plugs.

Fostex dries and peels the skin

◂ The Sebulytic base of Fostex dries and promotes peeling of the skin . . . actions enhanced by the keratolytic effects of micropulverized sulfur and salicylic acid.

*(Sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate, sodium dioctyl sulfosuccinate.)

Fostex is easy for your patients to use

FOSTEX CREAM
for therapeutic washing of skin in the initial phase of acne treatment, when maximum degreasing and peeling are desired.

FOSTEX CAKE
for maintenance therapy to keep skin dry and substantially free of comedones.

◂ Patients stop using soap on affected skin areas. Instead they use Fostex for therapeutic washing of the skin. The Fostex lather is massaged into the skin for 5 minutes—then rinse and dry.

WESTWOOD *Pharmaceuticals*
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Toronto 10, Canada

Study Tour

In the fall some 30 British nurses will be visiting Canada for a Study Tour planned by the CNA. Due to the limited time available to these visitors— approximately 3 weeks — they will only have time to visit Montreal, Toronto and Ottawa. The nurses will be divided into groups of eight and will have an opportunity to observe the field of nursing of particular interest to them.

Grateful Thanks

National Office and, in fact, Canadian nursing as a whole gratefully acknowledges the tremendous contribution made by the nurses of Ontario and particularly by the nurses of Ottawa to the success of the CNA Biennial Meeting.

To these nurses under the capable chairmanship of Miss **Ethel Gordon** we owe a real debt of gratitude.

Le Nursing à travers le pays

Cuillers-souvenir, au chiffre de l'A.I.C.

Avez-vous vu les jolies cuillers à café en argent, portant le nouvel écusson de l'A.I.C., qui étaient en vente au Congrès de juin qui a marqué le 50ième anniversaire de l'Association? L'écusson est en couleur ce qui produit un très joli effet. Avez-vous l'intention de commencer une collection de cuillers à café? Voilà l'article pour débuter. Toutes les infirmières désireront avoir une de ces jolies cuillers.

Les profits de la vente de ces cuillers seront versés au fonds spécial du projet d'Evaluation des Ecoles d'Infirmières. La cuiller se vend au prix de $2.50.

L'A.I.C. est votre Association

Chaque congressiste a reçu gratuitement un exemplaire de *L'A.I.C. est votre Association*. Cette brochure a été entièrement revisée et est publiée en français et en anglais. L'on peut se la procurer gratuitement en s'adressant au Secrétariat de l'A.I.C. Le but de cette publication est de faire connaître l'A.I.C. et ses activités, à ses membres, aux étudiantes et à ceux qui travaillent en collaboration avec les infirmières. La brochure est facile à lire, concise et intéressante.

"Les Mains qui guérissent"

Dans le numéro de juin, nous donnons dans cette colonne la description d'un film portant ce titre et préparé par le Ministère de la Citoyenneté et de l'Immigration.

Nous sommes heureuses d'annoncer que le Ministère a gracieusement offert un exemplaire de ce film à l'A.I.C. Il nous fera plaisir de le prêter aux infirmières que s'occupent d'orientation dans les écoles.

Voyage d'études

Cet automne, une trentaine d'infirmières de Grande-Bretagne visiteront le Canada. Ce voyage d'études a été préparé par l'A.I.C. La durée du voyage étant limitée à environ trois semaines, nos visiteuses n'auront le temps que de visiter Montréal, Toronto et Ottawa. Ces infirmières seront divisées par groupes de huit, et pourront voir dans les domaines du nursing les choses qui les intéressent particulièrement.

Journées d'études pour les secrétaires

En septembre dernier, vous avez probablement lu, sous cette rubrique, que des journées d'études devaient être organisées pour les secrétaires et les registraires des dix associations provinciales d'infirmières et de l'A.I.C., et se tenir à Montréal. Vu les nombreux préparatifs qu'a exigées la première Conférence Canadienne sur le Nursing, et le personnel restreint, au secrétariat national à cette époque, il fut décidé de remettre ce projet à 1958.

Ces journées d'études auront donc lieu dans la semaine du 15 septembre prochain, à l'Ecole des Infirmières de l'Université de Toronto. Parmi les conférenciers, il y aura des hommes de loi, des représentants de l'Association Canadienne pour l'éducation des adultes; l'on y traitera de l'administration, des relations industrielles, de la Gendarmerie Royale et de la profession d'infirmière.

Cette conférence, la première d'une série,

HEINZ Baby Foods proudly announce 5 new Fruit Juices...

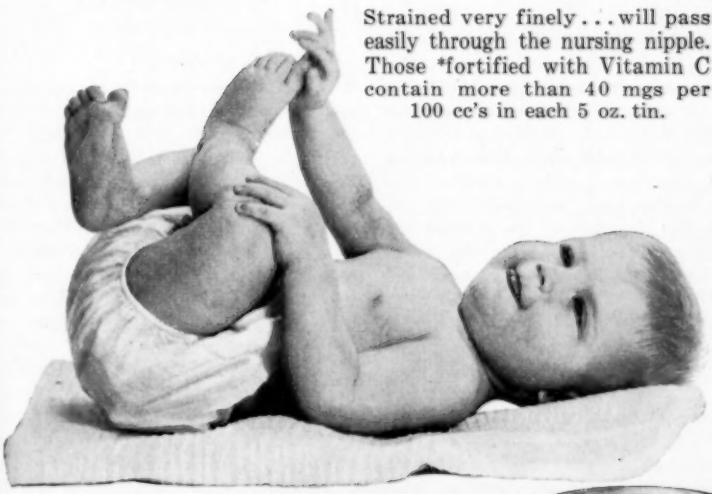
APPLE-PINEAPPLE JUICE

APPLE-GRAPE JUICE

*APPLE JUICE & APRICOT NECTAR

*APPLE JUICE & PRUNE NECTAR

PRUNE NECTAR ...with natural laxative properties



Strained very finely . . . will pass easily through the nursing nipple. Those *fortified with Vitamin C contain more than 40 mgs per 100 cc's in each 5 oz. tin.

The HEINZ line of Strained Fruit Juices is now seven-strong . . . including the familiar and popular Orange Juice and Apple Juice.

FREE SAMPLES for tasting or testing . . . write Heinz Baby Foods, Leamington, Ontario.

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MORE THAN 140 KINDS

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devrait être extrêmement utile aux infirmières qui ont la responsabilité des fonctions complexes que comporte la direction de nos associations professionnelles.

Onzième Assemblée de la Santé Mondiale

Mlle **Alice Girard**, notre nouvelle présidente, a assisté à la 11ième assemblée de la Santé Mondiale qui eut lieu à Minneapolis en mai dernier, à titre de représentante du C.I.I. Assistaient à cette importante réunion: Mlle Liselotte Felber, de l'Autriche, Mlle Carmen Bendoyro Mas, Cuba, Mlle Eila Kauppinen, de la Finlande, Mlle Myrtle Webb-Johnson, de la Grande-Bretagne, Mlle Hermien Coehoorn, des Pays-Bas, Mlle Leah Wilner, d'Israel, Mlle Matsu Kano, du Japon, Mme Janet Buckle, du Libéria, Mme Rosario Perpinan, des Philippines.

Sincères remerciements

Le Secrétariat national, voire L'Association des Infirmières Canadiennes désire exprimer toute sa gratitude aux infirmières de l'Ontario et tout particulièrement à celles d'Ottawa pour leur énorme contribution au succès du Congrès Biennal de l'A.I.C. Pendant des mois, des comités ont travaillé en collaboration étroite avec le Secrétariat national pour mettre la dernière main à l'organisation du congrès de juin dernier.

Envers toutes ces infirmières, sous l'habile direction de Mlle **Ethel Gordon**, nous avons une dette de reconnaissance.

Among the Miskito Indians

IRENE M. PROCHNAU

IT WAS A BRIGHT, clear sunny morning in the beginning of a new clinic week and the native pastor had just finished having a devotional period with the patients awaiting medical attention. Astria, a Miskito girl trained to help with the clinic work, was busy finding the patients' charts from the filing cabinet. Those who came for worm medicine had not had their breakfast and had to hurry to drink their glass of worm oil before they starved (so they said).

Why anyone would be in a hurry to drink that bitter oil of chenopodium one can hardly understand. Poor sanitary conditions and lack of shoes on their feet make it difficult to prevent reinfection with intestinal parasites and as a result worm medicine is taken routinely once or twice a year.

While Dr. Marx is having a consultation with another patient before physical examination, the nurse gives medications to the patients on routine T.B. treatment. At present there are about 10 patients who come weekly for treatment, but there should be more since nearly every household has at least one member of the family infected with the disease. Two main factors combine to account for this casual attention to coming for treatment. The first is poverty. With only a few dollars to their name, often only five cents, it is obvious that their money will not reach very far in covering the cost of the required medicines. Then there is the lack of understanding of the necessity for continued treatment. After two or three weeks of treatment the patient feels much improved and does not come again until another relapse occurs.

In the course of the morning some three to four patients have come to have teeth pulled. In the laboratory there are stool specimens to be examined for intestinal parasites or amebae, as well as other work as ordered. From another village, ordinarily three to four days' paddling on the river from here, the Mission Aviation Fellowship Piper plane arrives with a stretcher case — x-rays to be done. A dislocated disc is diagnosed and a body cast is to be applied in the afternoon. Beside our clinic stands a one-room infirmary, built native style, in which is a bed and chair. The rest of the space is used for the family and relatives who have come to stay with the patient and help care for him.

After getting the patient settled in bed we are now ready for a "coffee break" before returning to the rest of the patients waiting to be seen. Making appointments is impossible. Since nobody owns a watch they

---

For the past few years, Miss Prochnau has been serving with the Moravian Mission in a remote Indian settlement on the northeast coast of Honduras, Central America. She returned to Canada recently.

Make Nursing

an adventure

with practical advantages

As a Nursing Sister with the Royal Canadian Army Medical Corps, you get the excitement of adventure and travel . . . serving with Canada's Army at home and overseas.

Opportunities exist to work in the various fields of nursing such as teaching and supervision, nursing administration, public health, and operating room techniques and management.

You receive officer's pay, allowances for uniforms, food and accommodation, plus 30 days annual holidays with pay.

You may apply for a Regular Army appointment for a lifetime career, or a Short Service Commission whereby you engage for a period of three, four or five years.

If you are a Registered Nurse, under 35 years of age, and a Canadian citizen or British subject, write now for full information, without obligation to:

Director General of Medical Services, Army Headquarters, OTTAWA, Ont.

tell time by the position of the sun. By noon, the end of our clinic hours, we have seen a total of 50 patients. This is what we, the staff of "Clinica Evangelica Morava" in Ahuas, Dept. Gracias A Dios, Honduras, know to be a typical Monday morning. Outside the medical work itself and yet in direct connection with it is the buying of produce from the patients in exchange for medicine; three eggs will buy one adult dose of camoquine for malaria, for example.

Little Suzie, born prematurely while her mother was having an acute attack of malaria, weighed 3 lb. at birth. Survival was impossible in her home environment. Thus Suzie came to live with us for her first month. Mrs. Marx and I changed shifts every 24 hours for her necessary nursing care. You can be sure she became quite a part of us and still is known as our "premie." Until she was 8 months old, her little brother or sister came for her formula twice a day. Many a time this was a reminder of how fortunate most babies here are to be breast-fed, for the ingredients of a formula are not available to the average Miskito woman.

A 12-year-old girl brought to us from Laka (approximately 2 days and 2 nights paddling on the river from here), was in a critical condition. Malnutrition, tuberculosis, acute attack of malaria, as well as intestinal parasites accounted for her present state. "Give her all the strong injections and pills you have, doctor, so she can get well fast," were the anxious words from the father. The necessary medications were given and the parents were told she would require long-term treatment.

Immediate improvement was not evident "But the medicine man might have a quick cure," thought the parents. After the medicine man finished casting his spell on the child, she began to improve. Naturally in their way of thinking it was the medicine man who had given help instead of the medicine given some hours previously. Some days later the child died. "But that was due to the evil spirits, not lack of proper treatment," claimed the father. Superstition still remains one of the greatest hindrances in the improvement in their living conditions as well as their spiritual lives. One medicine man thinks he can die and then live again. To this day he has many people convinced he died three times but still is alive.

A visit to a native hut gives you a picture something like this. Built of bamboo with a leaf roof, the hut stands directly on the ground which serves as the floor. In one corner of the hut stands the family bed. Occasionally you will see two beds, but these are shared by a family of 6 or 8. Above the bed is tied the mosquito bar. This is put down at night (like a cage over you), to prevent the mosquito bites and thereby lowering the incidence of malaria. In another corner is a little clay stove built out of mud. There is a large iron pot used for cooking the meals. Green cooked bananas are often all they have three times a day for months. They may have rice or beans as well as casava when a crop is harvested. They cannot see the value of storage for the months ahead but eat what they can in one day and then live on green bananas the rest of the time. Oranges and other fresh fruits when in season add variation to the diet. Water for drinking or cooking is bailed from the near-by creek, which is also the swimming pool, bathtub, and tub for washing the clothes. Is it any wonder that nearly everyone at some time or another is infected with intestinal parasites or amebae?

In recent years some advancement in living conditions has been evident, but much remains to be done. With the organization of schools, the church and government in each village, we look for the day when this tribe will recognize their responsibility towards God, their country, and to themselves.

What sort of person do we wish our young Canadian to be? What will he be like if he embodies the best in the Canada around him? He will have some reverence for the past, a respect for what has gone before. He will have kept some of the simple virtues of an earlier time which will help him to sort out the real from the counterfeit. He will think for himself with respect for the views of others. He will work hard and play hard and know how to use his increasing leisure. He will have resources within him to keep him independent of the mechanized pleasure of the age. He will be able to laugh at the sight of absurd and will become angry at the sight of injustice. He will not be ashamed of good manners. He will show an inherited instinct for freedom. He will nurse a personal devotion to the welfare and the safety of his country. He will have a deep and quiet belief in what she is and what she can do.

—VINCENT MASSEY

* * *

Prejudice, which sees what it pleases, cannot see what is plain. —AUBREY DE VERE

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...softest ever...prevents suture irritation

NOW A COMPLETE PRE-PACKED LINE FOR MATERNITY CARE!

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MATERNITY PADS
No. 650
One dozen 12" KOTEX in bag. For bedside table and for patient's home use.
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Complete maternity care in a single package. 12" KOTEX plus 4 cotton balls.
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Pre-wrapped individual 12" KOTEX. Use bag for discarding pad.
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One dozen 8" KOTEX in a bag. For routine sanitary care.

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Nursing Profiles

Dorothy May Lounsbrough has been appointed as instructor in the school of nursing of the University of Western Ontario. A graduate of Victoria Hospital, London, she obtained her degree of bachelor of science in nursing from the University of Western Ontario in 1951, completing her studies for her M.A. at Teachers College, Columbia University in 1957.

Miss Lounsbrough was on the staff of the Victorian Order of Nurses from 1951-57 with an interruption of one year to complete requirements for her Master's degree. When she left the Order to take up her present

DOROTHY MAY LOUNSBROUGH

duties she was a senior nurse of the Toronto Branch. Interested and an active participant in the work of professional organizations, she enjoys travelling and photography when duties permit.

Dorothy Marianne Dix assumed her duties as a lecturer in nursing education of the school of nursing and instructor in hospital procedures of the medical school, University of Western Ontario, some months ago. A graduate of the Toronto General Hospital, she obtained her B.Sc.N. from the University of Western Ontario in 1951 and returned to the teaching staff of her home school.

In 1954 Miss Dix joined the Ontario De-

DOROTHY M. DIX

partment of Health as inspector for schools of nursing in the province. She remained in this office until appointed to her present position. Her interest in professional activities has always been intense. One of her most recent duties was to act as the RNAO representative to the advisory committee for the course for nursing assistants offered by the H. B. Beal Technical and Commercial High School. Busy as her professional life may be — she is presently studying for her Master's degree from Columbia University — Miss Dix still finds leisure time to enjoy photography, travel and a variety of other interests.

Margaret Edith (Granlin) Shaw has been appointed provincial director of nursing

MARGARET SHAW

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aide education for the province of Alberta. A graduate of the Royal Jubilee Hospital, Victoria, Mrs. Shaw obtained a diploma in supervision and administration. She served for a time as assistant night supervisor at her home hospital.

For several years Mrs. Shaw was in charge of the X-ray Department of Calgary General Hospital. She left this position to join the staff of the nursing aide school in Calgary and became principal of the school in 1956. With the opening of a second school for nursing aides at Edmonton, Mrs. Shaw's experience in the field, her efficiency as a nurse, her ability as a leader and her gracious personality made her a happy choice for her present position.

(McKittrick's)

JACQUELYN PEITCHINIS

Jacquelyn Alexandra (Elliott) Peitchinis is an instructor in nursing education at the school of nursing of the University of Western Ontario. In addition Mrs. Peitchinis is instructor in hospital procedures in the medical school.

She is a graduate of the General Hospital, Hamilton and obtained her B.Sc.N. from the University of Western Ontario in 1956. She is presently completing requirements for her Master's degree in science from Boston University. Immediately following graduation, Mrs. Peitchinis joined the staff of her home hospital where she worked as a staff nurse and later as assistant supervisor in the operating room. Prior to her present appointment she was a member of the teaching staff of Victoria Hospital, London.

Two researchers recently concluded from studies of pollen and mold fall-out that a city should be safer from atomic fall-out than the surrounding country. Only in the event of a direct hit would the city be more dangerous.

A city is usually warmer than the surrounding country. The rising warm air currents above the city carry solid particles — pollens, molds, and radioactive particles — aloft and keep them there. They fall to the ground when there are no upward air currents, especially when the air nearer the earth is cooler than the air above it. This knowledge could be applied to prevent "the hysterical exodus from a city to a more dangerous rural area in the event of an atomic attack."

The city could be made even safer, by artificially increasing the city's naturally high temperature. This could be done by heating houses, turning on street lights, and opening windows on the leeward side. Even an isolated village or a single residence might derive some protection by lighting fires on the windward side, which would produce upward air currents.

The researchers constructed a model city above which they scattered mold spores. The powder then resembled a cloud that settled slowly and unevenly upon the miniature buildings and lawns. When the city was warmed slightly to a temperature above that of the air, the clouds over the city billowed perceptibly but kept their distance from the ground and were finally dispersed over the rural areas.

The researchers also took pollen and mold samples from the air above and about a city on the west shore of Lake Michigan at a time when the wind was from the southeast. They found that the "country" pollen count, as represented by the count made on the south, or windward, side of the city was the highest. The lowest was on the northwest, or lee, side.

The wind carrying pollens and molds blew horizontally over the country south of the city. Then it met the warm air rising over the city, which pushed up the air containing the pollen and molds. In that case, there was no fall-out over the city.

Fall-out happens this way: When pollens and molds get high enough, they become stable because rising warm air holds them up. When the air below becomes cooler, it stops rising and the pollen falls. The greatest fall-out ordinarily occurs at night and early morning.

— NORTH CAROLINA *Health Bulletin*

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Book Reviews

You and Your Operation by Benjamin R. Reiter, M.D. 144 pages. The Macmillan Company, New York. Brett-Macmillan Limited, 132 Water St. S., Galt, Ont. 1957. Price $3.50.

Reviewed by Miss Zina L. Hopwood, Ste. 17, Greenbrier Apts., Belgrave Ave. S., London, Ont.

Dr. Reiter is indeed to be commended upon his desire to lessen the fears of pre- and postoperative patients. His book is an easily read, conscientious attempt on the part of a surgeon to take the "awe" out of "operation."

Of interest to professional people, attuned to the gruesome realism of surgery in the Dark Ages, but apt to be less than tranquilizing to an imaginative preoperative patient, is the first chapter on, "The Origins of Surgery." The average patient considers himself to be in sufficient "hot water" without contemplating the agonies of 16th century soldiers whose open wounds were treated with boiling oil!

The chapter entitled, "Some Special Hospital Procedures" is one of the most valuable. With simple, kindly clarity, Dr. Reiter explains the "how and why" of procedures about which most patients have not the faintest concept. Any prospective candidate for the operating room should benefit greatly from such knowledge.

Chapter 9 deals with "The 'Fearsome' Five" — colostomy, radical mastectomy, hemorrhoidectomy, hysterectomy, amputations. Chapter 10 is devoted exclusively to cancer. Other chapters concern "The Anesthetic," "The Operating Room," and "After the Operation." One wonders — is the printed page the *best* way to acquaint a patient with this information? Would not 15 minutes conversation with his own trusted surgeon, his own intelligent nurse, satisfy the immediate needs? And would not that information, followed by day-to-day explanations, be less traumatic for the patient when given in the warm, reassuring presence of those who are caring for him?

Dr. Reiter mentions the friends who stayed a whole hour just as the postoperative patient was getting ready for a little nap, and who were promptly followed by dear Aunt Susie, who stayed another hour. It is not quite clear whether the nurse failed to note "the pathetic look" on the patient's face or whether Dr. Reiter was making a personal comment on the popular policy of "open" visiting.

The writer gives excellent advice in "What Can the Patient Contribute?" He urges the patient to give the doctor a good history; to have confidence in his surgeon; to disregard well-intentioned friends who offer detailed information regarding their own surgical experiences; to have courage; and — to stay thin!

Dr. Reiter's admirable little book would be of most value in a school of nursing library. In the hands of an apprehensive patient, who might only skim the contents, it could add to, rather than detract from, a layman's fears — and *that* would be farthest from Dr. Reiter's intention.

Integrated Anatomy and Physiology by Carl C. Francis, A.B., M.D. and Gordon L. Farrell, M.D. 600 pages. The C.V. Mosby Company, St. Louis, Mo. 3rd Ed. 1957. Price $5.85.

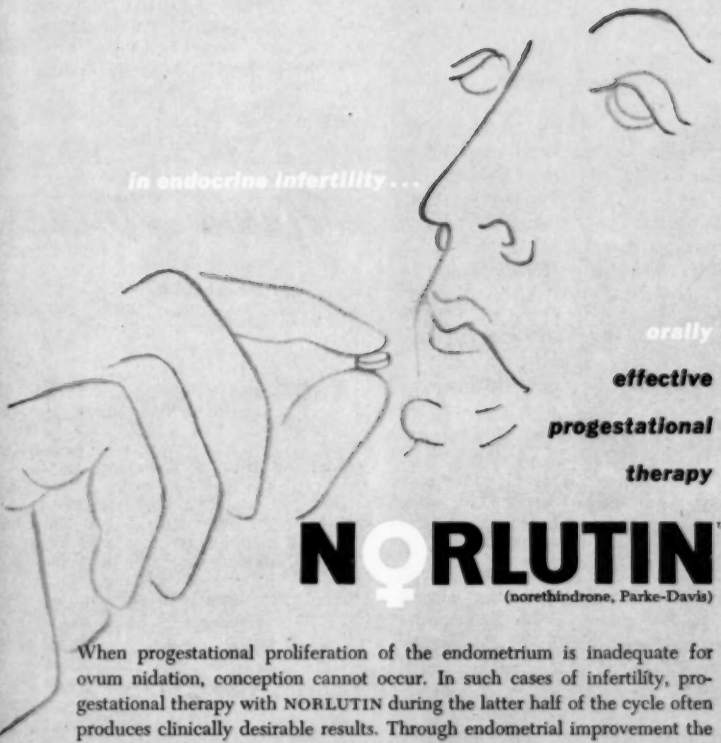
Reviewed by Sister Miriam, Science Instructor, St. Mary's Hospital, Montreal.

This edition of their textbook on anatomy and physiology has been so extensively revised that the change in the title was deemed necessary by the authors.

The sections on physiology have been rewritten. Much of the material has been re-arranged, and the number of chapters has been increased. The authors have considered the various organ systems and in turn have presented the anatomy and physiology of each. In some areas it has been possible to discuss both within a single portion of one chapter. In other areas it has been necessary to devote several chapters to a single system.

This text makes a knowledgeable contribution to the subject with which it deals. The presentation of Unit III — Integrative Mechanisms — deals with the nervous system in such a clear, descriptive manner that it should be of particular interest to the student.

This book has been designed as a textbook for the student who requires a basic knowledge of the human body and a general concept of its functions. It is a compact presentation including newer developments in metabolism, endocrinology, the role of vitamins and muscle physiology.



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*Rock, J.; Pincus, G., & Garcia, C. R.: *Science* 124:891 (Nov. 2) 1956.

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Fundamentals of Chemistry and Applications by Charlotte A. Francis, A.M. and Edna C. Morse, R.N., A.M., Ed. D. 518 pages. New York: The Macmillan Company. Brett-Macmillan Limited, 132 Water St. S., Galt, Ont. 4th ed. 1956. Price $6.00.

Reviewed by Miss Patricia O'Dwyer, Instructor in Science and Surgical Nursing, Metropolitan General Hospital, Windsor, Ont.

This book is intended for use in a brief course in chemistry, to help make more meaningful such subjects as fundamentals of nursing, physiology, microbiology, pharmacology and nutrition. The content is selected from inorganic and organic chemistry and biochemistry. The general plan is according to that recommended for a course in chemistry in the "Curriculum Guide for Schools of Nursing," National League for Nursing Education.

Somewhat more than one-half the book is devoted to the presentation of fundamentals necessary to a basic course in chemistry. Oxygen is the only simple substance studied in detail. One chapter is devoted solely to the energy transformations accompanying matter transformations in many chemical reactions.

The material involving molecular and atomic weights is likewise presented in great detail. The use of symbols and formulas as abbreviations of the written names for elements and substances is discouraged, as is the use of the *formula* equation as a convenient substitute for the *word* equation.

Organic and biochemistry are integrated to afford a better understanding of carbohydrates, fats and proteins in digestive and metabolic reactions.

The final chapter on the physiological functions of salts, deals with the reactions through which salts aid indirectly in obtaining optimum hydrogen-ion concentration for digestive reactions and in maintaining the hydrogen-ion - hydroxide-ion concentration relationship within body fluids. The reactions which are contributing mechanisms toward carbon dioxide and oxygen exchange in the lungs and cells are also included.

The style of writing is both interesting and easy to understand. A list of comprehensive questions follows each of the 32 chapters. It should be useful as a textbook for students chiefly concerned with applied sciences, who are receiving only a brief course in chemistry. It would have value as a reference text throughout the study of physiology, microbiology, nutrition and clinical pathology.

Nursing Sisters' Association

The following is a list of the executive members of the **Montreal unit** for the current year: Mary Roach, pres.; E. Robson, N. Kennedy-Reid, vice-pres.; Mrs. E. McNaughton, B. Herman, directors; I. O'Reilly, rec. sec.; E. Johnson, corr. sec.; E. Cumbers, treas.; M. Stewart, social convener; Mrs. R. Babbage, rep. to Local Council of Women.

News Notes

ALBERTA

District 3

Calgary

A $100 bursary has been awarded to a prospective student of the General Hospital. It was decided that a gift subscription to *The Canadian Nurse* would be paid by the chapter for Miss W. Gray who has been in India for the past 10 years as a nurse-missionary. A motion was submitted by this chapter to the effect that the Council of the A.A.R.N. should draw up a brief regarding the importance of standards of general education in Alberta as nursing education is affected. This brief is to be submitted to the Cameron Commission.

District 4

Medicine Hat

Sixty-nine members attended the annual chapter dinner held earlier this year. Students of the graduating class of '58 from the local hospital were the guests of honor. A rededication service for all nurses in the area was held at St. John's Presbyterian Church.

Provost

A report on the Canadian Conference on Nursing formed part of the program of a recent chapter meeting. Mrs. Fiske and Miss McKay attended the provincial convention in Banff as official delegates. Mrs. G. McCarthy, a recent bride, received a gift from the chapter as a token of their good wishes.

District 7

Edmonton

General Hospital

L. McKinnon, newly elected president of the Student Council, and H. Rehman were chosen to attend the Biennial Convention of the CNA. M. Schumacher, School of Nursing Adviser, visited in April. Two students from the University of Alberta spent some time at the

hospital as part of their field work program. Recent guest speakers in the school of nursing have been J. B. Feehan, lawyer, who discussed "Local Government and Responsibility to the Community" and L. Markley, personnel manager, Simpson-Sears, who spoke on "Human Relations."

Sixty-two students received their graduating diplomas at a ceremony held in Jubilee auditorium early in May. J. Gerlinger received the medal for general proficiency and R. Pelkie won a scholarship. B. Bacha was honored for receiving the highest standing in theory. Social activities for the year closed with a fashion show sponsored successfully by the students of class 2A. Members of the faculty of the school of nursing attended the annual provincial convention in Banff.

Misericordia Hospital

Members of the alumnae association executive for 1958 are: Mrs. D. L. Rees, pres.; Mrs. J. J. Heaney, Miss Dorothy Wild, vice-pres.; Mrs. J. G. Craig, sec.; Mrs. R. E. Warden, treas.; Mmes. L. B. Hawgood, E. Tempest, Jensen, L. Giroux, Mahoney, A. E. Dych, P. Proskurniak, Misses D. Wild, S. Dick, committee conveners. The class of '48 held a reunion early this year in connection with the annual alumnae banquet. Sergeant Silvers, Narcotic Division, was the guest speaker at a recent regular alumnae meeting. The annual graduation banquet was held late in April at the Air Lines Hotel.

New members of the teaching staff of the school of nursing include: G. Hanks, obstetrical supervisor; N. Guydash, surgical supervisor; Mrs. D. Greenaway (Univ. of Alta.), medical clinical instructor; Mrs. S. Batt (Univ. of Alta.), surgical clinical instructor. Sr. St. Delphina has succeeded Sr. St. Rodolphe as director of the school of nursing. Recent out-of-town visitors have been Lyla (Cooper) Peever, Canora, Sask.; Mrs. (Adams) LaBrie, Grande Prairie; J. (Boon) Bowen, Devon; Mrs. (Hancock) Currie, New Mexico; Mrs. (McInnes) Cartwright, Esther, Alta. G. Edwards is working in Hawaii.

Lethbridge

A coffee party in honor of the members of the graduating classes of the local hospitals was held early in May. Plans for a refresher course for nurses in the area have been completed. It has been decided to set up a booth at the Exhibition as part of the nurse recruitment program.

Stony Plain

Members of this chapter have made plans to visit a school for retarded children to gain first-hand knowledge of the care and training required. To avoid the possibility of incorrect information reaching the public, two members have assembled data concerned with admission requirements for student nurses, financial aid available for students, and facts about nurse aide training.

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BRITISH COLUMBIA

COURTENAY

Mrs. W. K. Hind, president of the Plateau chapter, accompanied by R. Miller, vice-president and Sr. Carmichael, district counsellor, attended the annual provincial convention in Victoria. Miss N. Cunningham, University of Western Ontario, Miss L. Creelman, chief of the nursing division of WHO, and Dr. H. W. Hickman, principal of Victoria College, were special guest speakers at the meeting.

Thirty-four chapter members enjoyed a dinner meeting early in May. Mr. H. Woodland gave an illustrated address following it that was much enjoyed by all. Twenty-eight members attended commemorative services at the RCAF Protestant Chapel during the same month.

CRANBROOK

A regular chapter meeting followed by a district meeting was held in the nurses' residence of the local hospital earlier this year. An Easter bonnet drawing and a baking sale were organized to raise the funds necessary for the $200 bursary presented by the chapter. This was awarded in June to a member of the graduating class of the local high school.

NELSON

Chapter officers for the current year are: Mrs. Francis (Trevor) James, pres.; E. Butler, H. Brader, vice-pres.; Mrs. Evelyn (Reisterer) Trainor, sec.; Mrs. Marjory (Hammond) Buckley, treas. Jean Hood was in charge of both the junior and senior home nursing classes. A Red Cross loan cupboard is maintained as one of the services of the group. Mrs. A. Dahl was the convener of a successful nurses' ball earlier this year. Proceeds were used for the Bursary fund for student nurses. Bursaries were granted to two applicants this year. The program for one of the general meetings took the form of a panel discussion on nursing with students from grades XI and XII of the local high school participating. F. McLean attended the CNA General Meeting in Ottawa in June.

VANCOUVER

General Hospital

The 50th anniversary plans of the alumnae association include the following activities:

Wednesday, July 30, A.M. — Registration and coffee party, Nurses' Residence
P.M. — Hospital tours
Thursday, July 31, P.M. — Bus tours of the city
Buffet dinner at B.C. House
Friday, August 1, P.M. — Evening reception at H.M.C.S. *Discovery*

Mrs. Edith (McCaul) Pringle is the convener of the reunion. A nominal registration fee and an admission fee for each event attended will be charged. Mrs. Helen (Conner) Findlay and classmates are in charge of registration while Mrs. S. F. (Bridgeman) Hobbs and her classmates will be hostesses at the coffee party. Mrs. B. (Pepper) Nesbitt and the class of '42 are directing plans for the evening reception. Mrs. J. (McGill) McLaren has compiled a booklet on the history of the alumnae. The booklets will be available to all in attendance. Time has been allowed in the program for private class parties and attendance at certain Centennial celebrations.

J. (McGill) McLaren has been appointed as an instructor in the school of nursing. B. Gillies is now temporary senior instructor. P. (Forbes) Moyes has returned to the teaching staff. C. Bing has been awarded the British Commonwealth and Empire Nurses' War Memorial Fund scholarship for 1958. She left in April for a year's study in neurosurgery and neurology at the National Hospital, London, Eng.

VICTORIA

A regular meeting of the Greater Victoria District RNABC was held in April at the City Health and Welfare offices. The president, Miss M. McMillin, presided. There were 58 members present. Plans for the provincial annual meeting were discussed and official delegates were elected. Miss McMillin was nominated as official delegate to the CNA General Meeting, held in Ottawa in June. Following the business meeting, the program committee presented a short film on Africa.

MANITOBA

BRANDON

General Hospital

Miss E. Toft-Hansen, physiotherapist with the western branch of the provincial division of C.A.R.S., was the guest speaker at a recent regular meeting of the alumnae association. She gave her audience a word-picture of the work of the society, the treatment and services provided for persons with rheumatism or arthritis and the success of efforts towards rehabilitation.

Members of the graduating class of '58 were guests of honor at a dinner and dance held in the Prince Edward Hotel early in May. Mrs. W. A. Wood was the guest speaker at the dinner. Mrs. H. S. Perdue, president, represented the association at the CNA convention in June.

NEW BRUNSWICK

CHATHAM

Miss Trenholm, Nutrition Division of the provincial Department of Health and Social Services, was the guest speaker at one of the recent regular meetings of the Miramichi Chapter. She dealt specifically with reducing and special diets. Several "fad" diets were outlined with emphasis on their shortcomings. The importance of dieting only under medical supervision was stressed. E. MacDonald reported on the St. John Ambulance home nursing course that she is presently conduct-

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ing. Twenty-eight students are enrolled and 50 applicants were refused due to lack of facilities. A representative from this area attended the provincial convention in Woodstock.

Fredericton

Victoria Public Hospital

Almost 200 nurses gathered at the Lord Beaverbrook Hotel for the annual reunion dinner of the alumnae association. Mrs. R. Howie, pres., J. Anderson, hon. pres. and Mrs. A. Russell, vice-pres. received the guests. Members of the graduating class, Dr. and Mrs. R. A. MacIntosh and Mrs. D. Mundee, president of the Saint John branch of the association, were guests of honor. The class of '33 celebrated their 25th anniversary and each member present received a corsage of roses from the alumnae association. Miss Phyllis Langan made the presentation. A. Bradley, class of '58, was the lucky name winner of a gift certificate. Entertainment was provided by the "Four plus One" — a popular, local quartette. Dr. MacIntosh was the guest speaker of the evening and chose as his subject "Thoracic Surgery." His address was much appreciated by the audience.

Mrs. Mundee told briefly of the formation and activities of the branch in Saint John. The officers for the current year were elected. They are: J. Anderson, hon. pres.; Mrs. A. Russell, pres.; M. Brewer, Mmes E. Doyle, R. Brewer, vice-pres.; Mrs. T. R. Myles, rec. sec.; A. Downing, corr. sec.; Mrs. R. Thompson, treas.; Mmes D. Wickett, H. C. Balmain, executive members; Mrs. H. Atcheson, rep. to *The Canadian Nurse*.

Moncton

Twenty-four members attended a recent meeting of the chapter and heard Mr. Austin Malone, a representative of Eastern Securities, discuss savings and retirement plans for nurses. A film depicting the progress of a company and the management of its funds completed the program. The annual vesper service for nurses in this area was held in May. It was decided that a gift of books would be given to the member of the graduating class from each one of the local hospitals who obtained highest standing in the principles and practice of nursing.

A later meeting of the chapter was held at the nurses' residence of the Moncton Hospital with Miss Margaret Hollenbeck, president, in the chair.

Mrs. Gwen Herman was in charge of the program and with the assistance of Misses Peggy Rann, Rosella Robichaud and Dorothy Godfrey gave a very interesting demonstration on "Body Mechanics."

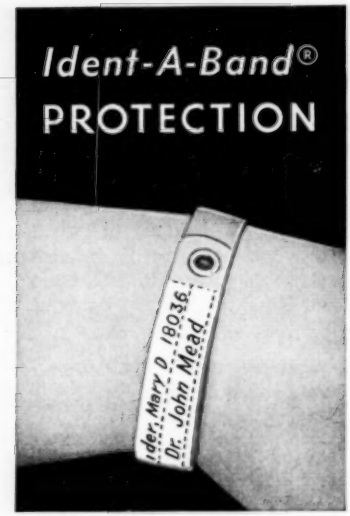
The annual meeting was held in June at the nurses' cottage at Shediac Cape in the form of a lobster supper. Miss K. MacRae was convener of the supper.

Saint John

H. Barry, secretary of the local chapter, attended the annual provincial meeting in Woodstock as an official delegate. E. Spencer, solicitor for the Department of Veterans' Affairs, was the guest speaker at a recent meeting. His subject was "Simplified Meeting Procedure."

"The Evolution of a Nurse" as seen through the eyes of D. McCarthy, junior student; Sr. Mary Ellen, an intermediate student; E. Geldart, senior student and Mary Ann Fuller, a recent graduate provided an interesting program for members at one of the chapter meeting. The discussion was under the direction of Sister Theresa Carmel, St. Joseph's Hospital.

In the recent qualifying examinations for registration, Doreen Blanch Thompson, a graduate of Saint John General Hospital captured top honors. Elizabeth Ann Harris, Charlotte County Hospital, placed second of all candidates writing, and Patricia Ann Theresa Smith, St. Joseph's Hospital, was third in line.



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General Hospital

The annual dinner and dance in honor of the graduating class was held at the Admiral Beatty Hotel. M. Moore was the convener of the event. The alumnae prize was awarded to the graduating student in the junior division of the class who obtained highest standing. A "bring and buy" sale has been planned for the first meeting in the fall when alumnae activities have been resumed. The members of the executive for the current year are: Mrs. R. Costello, pres.; L. Floyd, Mrs. G. Somerville, vice-pres.; B. Selfridge, sec.; Mrs. E. Purdy, treas.; Mrs. D. Crawford, asst. treas.; H. F. Stephenson, J. Johnston, Mrs. M. O'Neal, P. Harrity, committee conveners; Mrs. E. Mooney, historian; A. Thorne, G. Mantle, additional members.

NOVA SCOTIA

DARTMOUTH

Nova Scotia Hospital

The alumni association has carried out a busy program during the past season. A prize of $20 was awarded to the winners of a student debating team — Mr. C. Walkes and Miss Wilson. The Mental Health Society received a $10 donation and the Friendless Patients Fund, $20. A combined meeting of alumnae associations was held when invitations were extended to other hospitals in the area. The student nurses provided an entertaining program.

A party given recently with the student nurses as guests of honor provided members with a pleasant opportunity to get to know these prospective new members. A dance and banquet with members of this year's graduating class as guests of honor completed the season's activities.

WINDSOR

Payzant Memorial Hospital

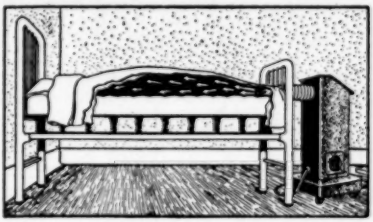
A pantry and variety sale with J. Davies acting as auctioneer helped to raise funds for the benefits of the student nurses. Mrs. E. Smiley was in charge of the program. J. Davies, Mmes. M. McDonald, H. Curry, Misses Elliott and Underwood provided the entertainment.

ONTARIO

LONDON

Ontario Hospital

Mrs. Nellie (Williams) Jones, a graduate of 50 years ago, was the guest of honor at one of the recent general meetings of the alumnae association. Mrs. Jones was presented with a life membership in the association and a lovely cameo pin. Many former graduates were present to extend their congratulations. Although retired from active nursing, Mrs. Jones has a keen interest still



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in the affairs of her alumnae association and professional activities generally.

WINDSOR

The Occupational Health Nurses' Association held a very successful Day Institute for its members and special guests. Some 85 nurses attended the sessions in the auditorium of the Personnel Building, Chrysler Corporation of Canada Limited. Greetings were extended by K. Reynolds, president of the association, and Mr. J. G. Craig, a director and vice-president in charge of Personnel of Chrysler.

Under the heading of "Personnel Security Program," a panel of three lawyers and the Director of Labor Relations for Chrysler discussed the methods of collective bargaining suggested for possible use to the RNAO. The advantages, disadvantages and action possible under each plan were explained. A film, "The Inner Man Steps Out," dealing with human relations, preceded a luncheon at which the guest speaker was Controller Mrs. Cameron Montrose. Choosing as her topic "Tomorrow is Ours," Mrs. Montrose emphasized the fact that women hold a controlling vote in this country if they wish to use it. She stressed the importance of women using their franchise and increasing their contribution to the national administration.

Dr. A. T. Wachna explained the new Poison Control Centre recently established in Windsor. The services of this centre are available on a 24-hour basis to everyone in the community. Dr. J. Berkeley, a specialist in physical medicine, described a pilot project in rehabilitation recently established in Windsor. A reception given by Ella Skinner Uniforms Limited, with Mr. F. Haddad as host, provided a pleasant and relaxing climax to an interesting day.

Grace Hospital

In mid-March, three staff members who have contributed almost 100 years of service to the hospital between them, were honored at a reception. Mrs. E. Dix, presently night superintendent, has given over 25 years of service while Mr. E. Higgins, laundry superintendent, and Mr. F. Wade, building superintendent, have contributed 36 and 30 years respectively. Certificates of merit provided by the Ontario Hospital Association were presented to each one by Dr. R. B. Robson, chief of medical staff. Senior Major Emily Woods who arrived in the city to take over the post of superintendent of Faith Haven was formally welcomed at a dinner meeting.

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DISTRICT 4

HAMILTON

General Hospital

Members forming the executive of the alumnae association for the current year are: M. Hudson, hon. pres.; M. Morgan, past pres.; Mrs. M. Moulton, pres.; Mrs. D. Parker, M. Charters, vice-pres.; J. Zorony, rec. sec.; R. Bowslaugh, asst. rec. sec.; W. Pinkney, treas.; D. Rumball, asst. treas.

DISTRICT 6

PETERBOROUGH

Civic Hospital

The Purple and Gold banquet was held in the Kawartha Room of the Empress Hotel late in May. Dr. J. C. C. Dawson was the guest speaker. The Community Nursing Registry's refresher course was held in the conference room of the hospital. Dr. Pratten discussed the newer trends in the treatment of mental illness and the drugs now in use.

DISTRICT 7

KINGSTON

Ontario Hospital

The alumnae association held a successful bridge and euchre party earlier this year. A reunion of graduates was held in June — the first time the association has arranged for such an event. The members of the graduating class of '58 were guests of honor at the reunion dinner. Mrs. Barbara Hunt has resigned from her position as nursing arts instructress. S. Potter has been transferred to the Ontario Hospital, Toronto. H. Lazarski and Mrs. P. Derbeyshire have returned to the teaching staff.

DISTRICT 8

OTTAWA

Lady Stanley Institute

The alumnae association held the annual dinner and business meeting in St. Giles Church hall earlier this year. M. Stewart, director of nurses, Royal Ottawa Sanitorium presided. Mrs. J. R. K. Main convened the dinner. Many guests attended from out of town and a very pleasant social evening was enjoyed by all present.

DISTRICT 10

PORT ARTHUR

St. Joseph's General Hospital

The alumnae association had a busy and interesting year of activities during 1957. A total of 10 monthly meetings was held as well as a successful rummage sale, bake sale, a Centennial tea, fashion show, doll raffle and the annual Nightingale ball.

The association, in conjunction with the school of nursing, undertook a project to raise funds to purchase approximately 100 books — reference and fiction. Anatomical models were added to the science laboratory.

An active part was taken in the City of Port Arthur's centennial celebration by holding a Centennial Tea on the hospital grounds. Alumnae members, dressed to represent famous nurses of bygone years, served the many guests. A float was entered in the parade, showing the old part of the hospital as it looked when Sister Monica, the foundress, first opened its doors to a needy public. Today only a remnant remains of that same old structure. Demolition has begun to make way for a huge, modern building, up-to-date in every detail.

The spacious auditorium of the Nurses' Residence proved a very suitable place for one meeting that was held in the form of a "get-together" dinner with the student nurses as our guests. Elections took place with the following list of officers named for the year: Sister Jovita, hon. pres.; Mrs. Margaret Woods, pres.; Mmes J. Wilmot, A. Hague, M. McLeod, vice-pres.; C. Alto, rec. sec.; Mrs. D. McDowell, corr. sec.; Mrs. D. Morin, treas.

QUEBEC

DISTRICT 11

MONTREAL

Members of the Nursing Service Committee, English chapter, ANPQ, displayed unsuspected talents when they presented a

skit entitled "A Little Cooperation Is An Excellent Thing." It was designed to show how nurses in many fields contribute to the welfare of the patient and his family. It emphasized the importance of communication between the various groups so that each complements the work of the others.

In this particular presentation, an industrial nurse, hospital staff including the head nurse, staff nurse, student, and private duty nurse, and a member of the Victorian Order of Nurses all had their contribution to make to the patient and her family. Mrs. Janice Wiseman of Trinity Players, Montreal, acted as adviser and director. The cast included Miss M. Smith, Miss R. McClusky, Miss M. McRae, Miss M. Reid, Miss C. Cox, Mrs. Murray, Miss D. Radcliffe and Mr. Josi Royes.

Royal Victoria Hospital

A total of $550 was recently donated to the E. Frances Upton Fund by the alumnae association. Mrs. Maureen (Hope) McIntosh has joined the teaching staff of St. Paul's Hospital, Vancouver. Ardice Buchanan is a staff member of the V.O.N. at Lindsay, Ont. M. Williams is with the Royal Canadian Navy, Shearwater, N.S.

District 3

Sherbrooke

The second general meeting of the district for this year was held in Norton Residence of Sherbrooke Hospital. The program for the evening was centred about a discussion of the present and future plans of *The Canadian Nurse* and the value of each nurse receiving her own copy. Misses L. Henshaw and J. Vaudry attended the CNA Convention as official delegates. Also present for various sessions were Misses C. Aitkenhead, G. Norris and D. Mewse.

Sherbrooke Hospital

Members of the staff association recently enjoyed viewing the film "Vitamin Deficiencies." A delightful fashion show — April Parade of Fashions — was presented by the student nurses. The latest creations for spring and summer were shown in a charming garden setting against a white picket fence and flower-covered arbor. The convener and commentator for the show, C. Wells, and her committee members, S. Parker and B. Deacon, deserve much praise for the success of this venture into the fashion field. Members of the student body were models for the occasion.

The officers of the alumnae association for the current year are: Mrs. N. Lothrop, pres.; Mmes A. Savage, M. Mandigo, vice-pres.; T. Gratham, rec. sec.; Mrs. A. Morrison, corr. sec.; Mrs. E. Taylor, treas.; Mmes. R. Cathcart, T. Michaud, H. Leslie, Miss F. Whittle, committee conveners; B. Littlejohn, rep. to *The Canadian Nurse;* Misses B. Boyd, N. Beattie, L. Lake, B. Harrison, Mrs. F. Stegmaier, executive officers.

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Director of Nursing for 91-bed hospital (Construction of new 240-bed hospital to commence as soon as weather permits. Excellent opportunity for an individual with initiative & organizing ability. Commencing salary: $340-$390 per mo. depending on administrative experience. Annual increments. Accommodation provided at nominal charge. Please address applications stating qualifications, experience & date available to Administrator, Prince George & District Hospital, Prince George, British Columbia.

Hospital Superintendent (Duties to commence June 15, 1958) for modern 28-bed hospital. Supervisory ability necessary. Excellent living quarters. Apply stating references, age, experience & salary expected to: Mrs. M. S. Leslie, Secretary, The Executive Committee, Bingham Memorial Hospital, Matheson, Ontario.

Matron: for modern 20-bed 5-bassinnette Hospital. Position open August 1st. S.R.N.A. salary schedule. Separate residence. Apply stating experience & references. Secretary-Manager, Riverside Memorial Hospital, Turtleford, Saskatchewan.

Superintendent of Nurses (1) for a 31-bed hospital. Salary-minimum $310 gross per mo. Consideration given to one with special preparation. 3-room suite wih all new furniture in a new nurses' residence just decorated. Fully staffed on 40-hr. working wk. 2 doctors on medical staff. Duties to commence July 1, 1958. Town 2000 population. Situated on highway. Excellent transportation connections to Edmonton & Saskatoon via C.N.R. & C.P.R. Application forms, conditions & policies governing appointment available on request. Write or phone to Miss G. M. Vigneron, Supt. of Nurses or to Secretary Manager, Union Hospital, Unity, Saskatchewan.

Assistant Matron with postgraduate preparation for 140-bed hospital with building program in operation. For further information, write Acting Matron, King Edward VII Memorial Hospital, Bermuda.

Assistant Superintendent and General Duty Nurses, for well-equipped 47-bed hospital. 8-hr. duty, 5½-day wk. Annual vacation with pay. Statutory holidays. Full maintenance in new modern residence. For further information apply: Superintendent, General Hospital, Kincardine, Ontario.

Supervisor (1) starting salary $264, less $33 for board & laundry; **Graduate Nurses** for general duty, **Registered Nurse (1)** for 3-11 P.M. Apply: Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ontario.

General Duty Nurses (2) duties to commence as soon as possible, working conditions, salaries etc., according to last schedule of the Saskatchewan R.N.A. Apply: Matron, or Secretary Manager, Nokomis Union Hospital, Nokomis, Saskatchewan.

Assistant Night Supervisor — Head Nurses for Medical & Surgical Wards — **General Duty Nurses** for 450-bed hospital with training school. Excellent personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

Operating Room Supervisor for large Sanatorium. Experience in Chest Surgery desirable. Salary according to qualifications. Good personnel policies. Apply Director of Nursing Service. The Beck Memorial Sanatorium, London, Ontario.

Operating Room Supervisor, Night Supervisor, Assistant Head Nurses. Excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

Assistant Operating Room Supervisor (1) for an expanding service. Postgraduate work & experience essential. For particulars, please apply: Director of Nursing, The Royal Alexandra Hospital, Edmonton, Alberta.

Medical—Surgical Instructor. R.N.A.B.C. personnel policies. Minimum salary: $3,600 per yr. Apply Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Clinical Instructors in Surgery & Pediatrics for 450-bed hospital. Good personnel policies. Please apply to: Director of Nurses, St. Joseph's Hospital, Victoria, British Columbia.

Pediatric Head Nurse, Head Nurses for General Wards, **Operating Room Nurses,** (postgraduate or equivalent experience). **General Duty Nurses** for 110-bed hospital in Fraser Valley, 68 miles from Vancouver, good bus service. A new 90-bed wing will be finished early this fall. Accommodation is available in a lovely new residence opened February 1958. Personnel practices in accordance with R.N.A.B.C. policies. Further particulars available. Apply: Director of Nursing, General Hospital., Chilliwack, British Columbia.

Registered Nurses (6) for 52-bed hospital. Salary: $240-$275, according to experience. 5-day wk. No night shift. 3-wk. vacation with pay, after 1-yr. service. Apply: Superintendent, St. Louis Hospital, Bonnyville, Alberta.

Infirmières Licenciées (6) pour service général — sont désirées à l'Hôpital (52 lits). Les salaires: $240-$275 selon l'expérience. Service de 40 heures, sans service de nuit. 3 semaines de vacances payées, après un an de service, en plus des 10 jours durant l'année. Veuillez adresser toute correspondance: Les Soeurs de la Charité de N.D. d'Evron, Hôpital St. Louis, Bonnyville, Alberta.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $230 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered Nurses (2) for general duty, Salaries $250-$290 gross. $60 per yr. for experience up to 3-yrs. increments $5 per mo. for ea. 6 mos. service. Residence & laundry provided. $30 for maintenance. For policies & info. contact. Mrs. O. M. Nicholson, Sec. treas. Fairview Municipal Hospital, Fairview, Alberta.

Needed dedicated Christian **Registered Nurses** for Esperanza General Mission (22-bed hospital). Opportunities for witnessing for the Lord. Salary: $100 clear. 6-day wk. 10-hr. day. Apply Dr. H. A. McLean, Ceepeecee, Vancouver Island, British Columbia.

Registered Nurses: for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered General Duty Nurses & Certified Nursing Assistants for new 58-bed hospital. Situated in North Western Ontario. Gross Salary $237 per mo. & $175 per mo., subject to increase after 6-mos. with regular annual increases thereafter. $45 per mo. room & board. Rail fare refunded after one year. New 21-bed nurses' residence-single rooms. Apply; stating age & when available to Director of Nursing, District General Hospital, Dryden, Ont.

Registered General Duty Nurses — for 300-bed Medical & Surgical Sanatorium. Good personnel policies. Starting Salary $240 per mo. — 40-hr. wk. Accommodation available. Apply: Superintendent of Nurses, Fort William Sanatorium, Fort William, Ontario.

Registered General Duty Nurses (4) for 105-bed Pembroke Cottage Hospital as replacements for ones who have been married. Pop. of town, 15,000. 8-mi. from Camp Petawawa, 2-hr. from Ottawa & 4-hr. from Montreal with excellent train & bus service. Active interesting community social life in heart of the beautiful Ottawa Valley. Active ski club, curling club & skating, also the home of the famous Pembroke Lumber Kings Hockey Team, 2-theatres & a "drive-in". Nurses residence is available if desired, 2 blocks from the hospital. Gross salary: $210-$235 with increase at the end of 6-mo. & 1 yr. 3-wk. vacation, 7 statutory holidays. 14-day sick leave. No night duty. Blue Cross Medical/Surgical participation. Forward application to the Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered Nurses for medical, surgical, obstetrical, pediatric & geriatric departments. Gross salary: $235, with annual increments. 5-day wk., 8-hr. day. 21-day vacation 1st & 2nd yr. 28-day, 3rd yr. Sick leave accumulative to 60 days. Transportation up to $50 paid after 1 yr. service. Community hospital in lake area. Apply: Director of Nursing, General Hospital, Port Arthur, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses: for United Church Mission Hospital at Hazelton, B.C. An Opportunity for Christian service. Salary $235 per mo. Write — Administrator, Wrinch Memorial Hospital, Hazelton, British Columbia, or if in Toronto contact Dr. M. C. Macdonald, Board of Home Missions, 299 Queen St. West, Toronto 2B, Ontario.

Registered Nurses required; medium 52-bed hospital in English speaking community 50 miles from Ottawa, Ont., Salary $192.50 per mo. with full maintenance, $10. extra for evening & night duty (2-wks.); Annual increase of 5% until maximum of $225 per mo. with full maintenance. Straight 8-hr. day, 44-hr. wk. statutory holidays, sick leave & annual leave. Fare advanced if required. Apply: Supt. Pontiac Community Hospital, Shawville, Quebec.

Registered General Duty Nurses for County Hospital 45 mi. from center of Montreal with excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Two theatres, bowling, curling & dancing. 8-mi. from summer resort on Lake St. Francis & 12-mi. from U.S. border. Gross salary: $215 per mo. Three $5.00 increases at 6-mo. intervals to maximum $230. 44-hr. wk. 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 1-mo. annual vacation, all statutory holidays. 2-wk. sick leave. Blue Cross paid. Apply: Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses (2) for General Duty, 96-bed hospital; new modern residence opening this summer. $250 starting salary less $20 if not Sask. or Alberta Registration. $10 increments yearly for 3 yrs. For particulars contact Supt. of Nurses. Lloydminster Hospital, Lloydminster, Saskatchewan.

Registered Nurses (2) for general staff duty in 8-bed hospital. Employee benefits include a 5-day-wk., salary range from $250-$320 per mo. according to experience, as compiled by the Sask. Registered Nurses Association. Full maintenance available in nurses residence at $30 per mo. For further particulars address enquiry to B.E.L. Magnusson, Sec. Treas., Hodgeville Union Hospital, Hodgeville, Saskatchewan.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Graduate Nurses for new 60-bed acute General Hospital with new residence. R.N.A.B.C. contract in effect with basic of $260 for R.N. Staff. Particulars from Superintendent of Nurses, Campbell River & District General Hospital, Campbell River, British Columbia.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses: Staff and Operating Room: Salary $300-$315 with periodic increases. Excellent personnel policies. For further information contact Superintendent, Red Wing City Hospital, Red Wing, Minnesota.

Registered Nurses: for general duty in 50-bed general non-profit hospital, an opportunity to work & live in the Evergreen Playground, midway between Seattle, Washington & Vancouver, B.C. Base Salary $285 per mo. with increments, differential for evening, night & special services, 40-hr. wk. paid vacation, sick leave benefits & public holidays, liberal personnel policies. Apply: Administrator, Memorial Hospital, Sedro Woolley, Washington.

General Duty Nurse (1) for rotating shift (30-bed hospital). Salary: $260 per mo. less $40 for room, board & laundry. 40-hr. work wk. 4-wk. vacation with pay after 1 yr. service. 1½ days sick leave per mo. yearly accumulative. Attractive nurses' home adjoining hospital. Apply: Community Hospital, Grand Forks, British Columbia.

General Duty Nurses. Salary: $260-$312, $13 increment for experience. 40-hr. wk. 1½ day sick leave per mo. cumulative. 1 mo. vacation. 10 statutory holidays. Must be eligible for B.C. registration. Apply: Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Graduate Nurses (2). Salary: $250. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $260-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Department of Public Health, Province of Alberta, invites applications for the following positions: 1. **General Duty Nurses** — salary $3,240 to $3,720 per annum 2. **Supervisor Nurses** (preferably with psychiatric nursing experience) — salary $3,540 to $4,080 per annum. 3. **Psychiatric Nursing Instructor** — to teach students taking a 3-yr. psychiatric nursing program, or to teach undergraduate nurses in an 8-wk. program — salary $3,960 to $4,680 per annum. Appointments to be made at active treatment hospitals, located at Edmonton & Ponoka, Alta. Residence, with board, if desired, $30 per mo. Excellent holiday, sick leave & pension programs. Apply: Supt. of Nurses, Provincial Mental Institute, P.O. Box 307, Edmonton, Alberta, or Provincial Mental Hospital, Ponoka, Alberta.

Come to B.C. during our Centennial Year! Applications are invited for positions, either permanent or holiday relief, on the staff of an acute general 50-bed hospital close to Vancouver. R.N.A.B.C. personnel policies in effect. Apply to: Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn. Boating, fishing, swimming, golfing, curling & skiing. Initial salary: $270. Maintenance, $45. 44-hr. wk. 4-wk. vacation with pay. Comfortable, attractive nurses' residence. Rail fare advanced if necessary. References required. Apply Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses. Starting salary: $260 per mo. & 4 annual increments of 5% to B.C. reg'd. nurses. $20 per mo. for one or more years university training & $10 per mo. for hospital postgraduate clinical training of not less than 4 mo. 28 days annual vacation after 1 yr. service, 10 statutory holidays per yr. 1½ days sick leave per mo. cumulative. Room rent at nurse's residence $20 per mo. Promotions to senior positions from permanent staff. For details apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for 55-bed hospital. Salary: $200 per mo. plus maintenance. Travelling expenses refunded on completion of 12 mo. service. Please apply: Director of Nursing, The Lady Minto Hospital, Chapleau, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $235 per mo. with annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $240 per month. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Nurses. O.R. Scrub Nurse (1). For modern well equipped 100-bed general hospital in friendly community. Gross salary: $240 per month if currently registered in Ontario. 8 hr. rotating shifts. 44 hr. wk. 1 day off 1 wk. and 2 the next. 21 days vacation after 1 yr. 7 legal holidays. Good personnel policies. Apply, Miss Willamene R. Allan, General Hospital, Port Colborne, Ont.

General Duty Nurses for 163-bed Tuberculosis Sanatorium. Good salary & personnel policies. Residence accommodation available. Please apply Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

General Duty Nurses for 100-bed modern hospital in south western Ontario. Please apply to: Director of Nurses, Tillsonburg District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurse (Immediately). Straight rotating, 8-hr. shift. For further information please apply to: Sister Superior, Hôpital Notre-Dame, Val Marie, Saskatchewan.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary: $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in psychiatry & pediatrics on a segregated service. Apply Superintendent, Community Hospital, Alamosa, Colorado.

Graduate Nurses (2) for newly decorated small country hospital in northern Alberta, (40 miles paved road to next city). Starting salary for Graduate Nurses, $220, less $30, room & board. Good working conditions. Foreign nurses also can arrange for registration. Fare will be refunded after 12-mo. service. Apply Matron, Hythe Hospital, Hythe, Alberta.

Graduate Nurses for: 64-bed hospital, 250 miles north west of Edmonton. Salary $240 if registered in Alberta, less $30 for maintenance; $5 increment each 6 mo. for 6 increases, 4-wks. vacation with pay after one year service, plus statutory holidays, residence, $50 travelling expenses refunded after one year of service. Apply: Sister Superior, Providence Hospital, High Prairie, Alberta.

Graduate Nurses; For new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Graduate Nurses (several) for future vacancies for modern 42-bed hospital in northern Ontario .Residential town, pop. 5,000 Over night by rail to Montreal & Toronto. Starting salary: $235 per mo. 40-hr. wk. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $320 with 4 annual increases to $360. Full maintenance $45 per mo. Liberal personnel policies. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

Supervisory & Staff positions available for 200-bed General Hospital (Heart of Los Angeles cultural & educational center.) General Duty: $320 per mo. minimum. ($20 dif. for 3-11 & 11-7.) Benefits: 40-hr. wk. Soc. State Dis. Ins. Reg. Salary included. 2-wk. vacation end of 1 yr. (3-wk. after 5 yrs.) 7 paid holidays. 12-day sick leave. Uniforms laundered. Nurses' res. $10 per mo. Graduates of accredited schools — Cal. license obtainable immediately. Apply: Mildred Croddy, R.N., Director of Nurses, Santa Fe Coast Lines Hospital, 610 South St. Louis St., Los Angeles 23, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Graduate Staff Nurse (Opportunities in the United States) for well-equipped 400-bed, non sectarian General Hospital affiliated with medical school. New salary rates: Day-shift, $340-$370 per mo., afternoon & nights, $370-$400 per mo. Comfortable, low-cost living accommodation available in attractive residence building. Apply to Director of Nursing Service, Mount Sinai Hospital, 2750 West 15th Place, Chicago 8, Illinois.

Operating Room Nurse and Registered General Duty Nurses for 100-bed General Hospital in attractive town on Lake Huron. Good personnel policies. Apply: Superintendent, Alexandra Marine and General Hospital, Goderich, Ontario.

Operating Room Nurses (2), General Duty Nurses for 60-bed General Hospital. Good salary. Paid life insurance & sick leave. Apply stating experience to: Director of Nursing, District Memorial Hospital, Leamington, Ontario.

Operating Room Nurse (P.M.) for 147-bed General Hospital located in a beautiful residential suburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. $375 per mo. Other employee benefits. Contact the Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Public Health Nurses: to commence August 1st. or September 1st. for Health Department, City of Calgary. Salary $3144 to $3816. 5 day wk. Pension & Sickness & Accident plans available. One Month's vacation after one yr. Apply: Dr. W. H. Hill, Health Dept., Calgary, Alberta.

Public Health Nurses for generalized program in Seaway Development Area. Group insurance & Blue Cross available. Good transportation policy. Apply: R. S. Peat, M.D., Medical Officer of Health, S.D. & G. Health Unit, 38 Augustus St., Cornwall, Ontario.

Public Health Nurse — generalized program, City of Guelph Health Dept. minimum $3,200 5-day wk. sick benefits, Blue Cross & P.S.I. benefits. Apply: Dr. Sutherland, City Hall, Guelph, Ontario.

Public Health Nurses (2) qualified. For a generalized program. 1, to be in charge, & 1 nurse for staff duty. Good salary. Generous car allowance. Duties to commence approximately August 15th. Apply: Gordon Cooper, Clerk, Township of Waterloo, Kitchener, Ontario. R.R.3.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurses (Qualified) for generalized program in city of 44,000. Starting salaries dependent on experience. 5-day wk. Month vacation. Blue Cross & P.S.I. employer shared. Accumulative sick leave & pension plans. Workmen's compensation. Group insurance. Transportation provided or car allowance. For further information please write, supplying details of training & experience to: Medical Officer of Health, City Hall, Peterborough, Ontario.

Public Health Nurse: for generalized program 20 miles from Toronto. Salary range $3,250 — $4,000. Allowance for experience. 4-wks. vacation; cumulative sick leave; Blue Cross; Group Insurance; Pension Plan. Apply: Dr. W. E. MacBean, Director, Ontario County Health Unit (Southern Area), Pickering, Ontario.

Public Health Nurses (Qualified) for generalized public health nursing service. Salary range: $3,388-$3,834. Starting salary based on experience. Annual increments. 5-day wk. Vacation, shared hospitalization, sick pay & pension plan benefits. Apply: Personnel Department, Room 320, City Hall, Toronto, Ontario.

Certified Nursing Assistants for immediate vacancies for modern 42-bed hospital. Residential town, pop. 5,000. Overnight by rail to Montreal & Toronto. Starting salary: $140 per mo. 44-hr. wk. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Matron (1) **Registered Nurse** for General Duty (1) **Practical Nurse** (1) immediately, wages $360, $260 & $180 respectively, new 16-bed hospital with nice living quarters etc. Please write or phone J. G. Stitt, Secy., Rossburn, Manitoba.

Registered Nurses (2) for 17-bed hospital; general duty; salary $240 gross with annual increments to $270. 44-hr. wk. 1-mo. vacation after 1-yr. Transportation refunded after 6-mo. service. Apply: Elnora Municipal Hospital, Elnora, Alberta.

Registered Nurses (3) for 31-bed hospital in September 1958. 40-hr. wk. salary $252-262, increments $5 every 6 mos. Single room accommodation in nurses home $10 per mo. Full board $30 or meals at 50¢ each. Steamship fare from Vancouver refunded after 6 months. For further information & copy of personnel policies, write to the Matron, General Hospital, Box 640, Ocean Falls, British Columbia.

Registered Nurse for general floor duty. Gross salary $275 per mo. with $25 deducted for full maintenance. 44-hr. wk. Yearly increments with standard holiday & sick leave benefits. Apply: John Hiscock, Sec. Treas., Baldur, Manitoba.

Registered Nurses for general duty in medicine, surgery & obstetrics; 20-bed private hospital. Rotating shifts averaging 42-hr. per wk. Salary $250 per mo., plus full maintenance. Accommodation provided in nurses' residence, single rooms. Liberal personnel policies; group insurance; pension plan; 1-mo. vacation after 1-yr.; sick leave. Excellent recreational facilities. Located in Thunder Bay District of Ontario, on main C.P.R. transcontinental line & Trans Canada Highway. Apply: Employment Supervisor, Marathon Corporation of Canada Limited, Marathon, Ontario.

Registered Nurses for shift duty in new general hospital to open July 1, 1958. Hospital of latest design & with most modern facilities. Additional help required in all departments. Apply: Director of Nursing, The Greater Niagara General Hospital, Niagara Falls, Ontario.

Registered Nurses (2) required immediately; 30-bed rural hospital; 8-hr. shift; 6-day wk. general duty; full maintenance. Apply Miss Frances Hardy, Matron, Phone 12J Gatineau Memorial Hospital, Wakefield, Quebec.

Registered or Graduate Nurses (4) for general duty in 45-bed hospital in town of 3000 pop. Salary $250 per mo. less maintenance of $30 per mo. $5.00 increments every 6-mo. Travel allowance of $50 refunded after 1-yr. of service. Duties to commence as soon as possible. For further information apply, Matron, Meadow Lake Union Hospital, Meadow Lake, Sask.

Registered Nurse for new 35-bed hospital in agricultural valley located 80 miles from Reno, Nevada. Starting salary $325 per mo. $10 differential for p.m. & nights, 5-day wk., 1 meal a day, laundry of uniforms, hospitalization policy paid by hospital & retirement plan. 2-wks. paid vacation, 10-days sick leave, 6 paid holidays. Contact: Administratrix, Lyon Health Center, Yerington, Nevada.

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. postgraduate course in Tuberculosis. Salary: $3,240 to $3,720 per annum. Openings also available for **General Duty Nurses.** Residence with board, if desired, $30 per mo. Excellent holiday, sick leave & pension benefits. Apply to: Superintendent of Nurses.

General Duty Nurses for modern 40-bed hospital in Okanagan Valley. Excellent personnel policies. Apply Director of Nurses, St. Martin's Hospital, Oliver, British Columbia.

General Duty Nurses for 600-bed teaching hospital in Central California. In-service educational program; Salary $337-396, 40-hr. wk.; 11 holidays annually, retirement & sick leave plan. Differential of $20 per mo. for 3:00-11:00 p.m. shift & $15 per mo. for 11:00 p.m.-7:00 a.m. shift. Write Personnel Director, 732 East Main Street, Stockton, California.

Surgical Registered Nurses, Staff Registered Nurses for 240-bed General Hospital. 40-hr. wk. 15 working days; paid vacation; 7 paid holidays; sick leave. Surgery starting base pay $338 stand by & call back time extra. **Staff R.N.** starting pay $322 monthly; regular pay increases; P.M. & night differential $10. Apply: Yolo General Hospital, P.O. Box 210, Woodland, California.

Operating Room Nurses for 370-bed approved General Hospital with an intern-resident program. 7 theatres; 650 to 750 cases monthly. Starting salary: $330 or $340 per mo. according to experience. $20 per mo. merit increases at 12, 24 & 36 mos. 40-hr. wk. 2-wk. paid vacation. Paid sick leave, 7 paid holidays. Resort location in California's finest recreational area. Apply to: Director of Personnel, Seaside, Memorial Hospital, 1401 Chestnut Ave., Long Beach 13, California.

Public Health Nurses qualified for generalized program in a city of 53,000. Starting salaries dependent on experience. Minimum salary $3,250, maximum $4,000, annual increment $200; transportation provided. Pension plan; Blue Cross; P.S.I. employer shared. 4-wks. annual vacation. Apply: Dr. C. C. Stewart, B.A., M.D., D.P.H. Medical Officer of Health, City of Oshawa, Ontario.

Public Health Nurses qualified for generalized program with City of Ottawa Health Department. Salary $3,390-$3,900 based on experience. Good personnel policies; 5-day wk. Superannuation; Blue Cross & P.S.I. benefits. Apply: Medical Officer of Health, City Hall, Ottawa 2, Ontario.

Public Health Nurses (qualified) for generalized program in York Township. Personnel policies & benefits similar to the other municipalities in Metropoliton Toronto. Arrangements for a pre-application interview can be made with the Medical Officer of Health, Dr. W. E. Henry, York Township Health Department, 2700 Eglington Ave., W. Toronto, Ont.

Public Health Nurses Qualified Generalized public health program in a combination visiting nurse association, City Health Department Nursing Service, Spokane City. Pop. 189,000. 37½-hr. work-wk., car furnished, social security, city retirement. Salary range, subject to experience, Public Health Nurse I $340-$368, Public Health Nurse II $368-$416, with annual increments. Apply: H. H. Trayner, M.D., M.P.H., Health Officer, Spokane City Health Dept., Spokane, Washington.

Public Health Nurses (Qualified) for the Toronto Branch, Victorian Order of Nurses. Salary range $3,320-$4,150, starting salary based on experience. Annual increments. 5-day wk. 4-wks. vacation. $100 uniform allowance. P.S.I. & Blue Cross available. Pension plan benefits. Apply: Director, 281 Sherbourne Street, Toronto, Ontario. Wa. 1-3184.

General Duty Nurses for 106-bed hospital. Starting salary $260 plus differential equivalent to yearly increment (5%) for 2-yrs. satisfactory experience which terminated within 2-yrs. 40-hr. wk. 28-dys. vacation plus 10 statutory holidays. Residence accommodation available. Fare refunded after 6-mos. service. Apply: Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

Registered Nurses (2) & Certified Nursing Assistants (2) for 34-bed general hospital, 40 mi. north of Guelph, Ontario. Please apply stating age & qualifications to: Superintendent, Louise Marshall Hospital, Mount Forest, Ontario.

Director of Nursing, immediately; with administrative ability; for new 58-bed Prince Edward County Hospital, now under construction. For full particulars apply: R. B. Small, Secretary-Treasurer, Box 471, Picton, Ontario.

Superintendent & General Duty Nurses. Apply: Mrs. Emery Robertson, Supt., Tobique Valley Hospital, Plaster Rock, New Brunswick.

General Duty Nurses (3) required immediately for new 54-bed hospital. Gross salary $255 per mo. with annual increase, less $26 maintenance. Group pension; medical & hospitalization plan; 44-hr. wk. 3-wks. vacation after 1-yr. service, plus 10 statutory holidays. Apply stating training; experience & references to Matron, Vermilion Municipal Hospital. Vermilion, Alberta.

Operating Room Supervisor for 110-bed modern hospital; excellent personnel policies. Apply: Superintendent, Charlotte County Hospital; St. Stephen, New Brunswick.

Registered Nurses (2) for 21-bed hospital 8-hr. rotating shift; salary $260 per mo. less $30 board; free laundry; increments after 6-mos. Residence attached. Apply: Matron Union Hospital. Vanguard, Saskatchewan.

Public Health Nurse (qualified). Generalized program includes some bedside nursing. Salary $3,200 to $4,250. Annual increment $150. 5-day wk. Car provided or car allowance. Apply: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Registered General Duty Nurses for 21-bed general hospital; salary $275 per mo. or $265 if not registered in B.C. Board & room in residence available at $40 per mo. 40-hr. wk. Apply: Matron, Burns Lake Hospital, Burns Lake, British Columbia.

Practical Nurses (4) qualified for 40-bed active hospital in Central B.C. pleasant working conditions; 40-hr. wk. 14-days vacation after 1-yr. 1½-days sick leave per mo. 10 legal days with pay per yr. salary $175-$200 according to qualifications; modern new residence available about the end of August; laundering of uniforms done gratis by hospital. Kindly apply giving references & qualifications to Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

Registered Nurses for General Duty new 20-bed hospital R.N.A.N.S. policies in effect. Please apply Superintendent, Eastern Shore Memorial Hospital. Sheet Harbour, N.S.

Registered Nurse & Licensed Practical Nurse required for modern 11-bed hospital; close to Clear Lake. Salary R.N. $250, L.P.N. $160 increases every 6-mo. 10 statutory holidays, vacation after 1-yr. Full maintenance $25 per mo., uniforms laundered free. Apply: Miss S. H. Manhard, Matron, McCreary Medical Nursing Unit, McCreary. Manitoba.

General Duty Nurses for general hospital in Niagara Peninsula. Residence accommodation available. Presently on 44-hr.-wk. but reverting to 40-hr.-wk. in September. Basic salary $245 both now & in September. 4 annual increments & 3-wks. vacation. Apply: Director of Nursing, Welland County General Hospital, Welland, Ontario.

Clinical Instructor (1) in Pediatric Nursing; **Clinical Instructor (1)** in Surgical Nursing; 5-day-wk. good personnel policies. Apply: Director of Nursing, Ottawa Civic Hospital, Ottawa, Ontario.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7 mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Registered Nurses (2) for general duty, B.C.R.N.A. policies in effect. Apply: Matron, Creston Valley Hospital, Creston, British Columbia.

POSITION WANTED

Experienced Lab., & X-ray technician, male, 45, wants to take full charge in an up to 50-bed hospital. Can start immediately. Box A, The Canadian Nurse Journal, 1522 Sherbrooke St. West, Montreal, P.Q.

QUALIFIED NURSING INSTRUCTOR

REQUIRED FOR TUBERCULOSIS AFFILIATION PROGRAM AND IN-SERVICE TRAINING — TO COMMENCE DUTIES IN SEPTEMBER.

For full information apply to the,
DIRECTOR OF NURSING, ROYAL OTTAWA SANATORIUM, OTTAWA, ONTARIO.

NURSES

FOR HOSPITAL IN KITIMAT, BRITISH COLUMBIA

MUST BE REGISTERED NURSES

80-bed hospital with staff of 27 nurses and 7 doctors. New 120-bed hospital under construction.

$281 per month starting salary

$307 per month after 3 months

$329 per month after 6 months

$355 per month after 1 year.

Very favorable working & living conditions.

For further information write to:

ALUMINUM COMPANY OF CANADA LTD.

Employment Department,
1700 Sun Life Bldg., Montreal, Quebec.

THE WINNIPEG GENERAL HOSPITAL

is recruiting

1. AN ASSOCIATE DIRECTOR OF NURSING EDUCATION:
   To supervise and assist in the organization and development of the educational program for the school of Nursing.
   Qualifications:
   a. Minimum, a B.A., or B.Sc. degree in nursing with considerable experience in supervisory and administrative capacities.
   b. Desirable but not essential, a Master's degree or equivalent education and experience.
2. CLINICAL SUPERVISORS IN MEDICINE & SURGERY
3. GENERAL DUTY NURSES FOR ALL SERVICES.

Please send applications direct to:

THE DIRECTOR OF NURSING,
THE WINNIPEG
GENERAL HOSPITAL,
WINNIPEG 3, MANITOBA.

REGISTERED NURSES

required by

SASKATCHEWAN DEPARTMENT OF PUBLIC HEALTH

Salary ranges: With diploma in public health $276-$337 per month; without diploma in public health $253-$312 per month.

Requirements: Registered Nurse & preferably some experience in public health nursing or in midwifery; to do public health nursing in various regions of the province.

Applications: Forms & further information available at Public Service Commission, Legislative Bldg., Regina. Applicants should refer to file No. c/c4574.

UNIVERSITY OF ALBERTA, CANADA,

requires tutor to instruct course in

ADVANCED PRACTICAL OBSTETRICS.

MUST BE QUALIFED MIDWIFE WITH MIDWIFE TEACHER'S DIPLOMA;

Apply:

DIRECTOR, SCHOOL OF NURSING, UNIVERSITY OF ALBERTA, EDMONTON, ALBERTA.

CLINICAL INSTRUCTOR (medicine or surgery)

University postgraduate; for 300-bed accredited general hospital school of nursing (87 students) 1 class annually; 42-hr. wk.; 1-mo. vacation; 8 statutory holidays; sick leave; pension plan.

Apply:

DIRECTOR OF NURSING, ST. THOMAS-ELGIN GENERAL HOSPITAL, ST. THOMAS, ONTARIO.

GRADUATE NURSES — SUBURBAN TORONTO

Are invited to enquire re: employment opportunities in a well-staffed new 125-bed hospital in suburban west Toronto. General duty salary range: $240-$290 per mo. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST. WESTON, TORONTO 15, ONTARIO. CHerry 4-5551.

NURSE INSTRUCTORS

required for Aug. 1, 1958

CENTRALIZED TEACHING PROGRAM

for

STUDENT NURSES IN SASKATCHEWAN

Classroom followed by Clinical program

(1) Prepared in Social Sciences (Psychology & Sociology)

(2) Prepared in Physical Sciences (Anatomy, Microbiology, Pharmacology)

S.R.N.A. Salary Schedule

Good personnel policies

Apply:

DIRECTOR, C.T.P.
REGINA COLLEGE, REGINA,
SASKATCHEWAN.

Applications are requested by

WOODSTOCK GENERAL HOSPITAL

SCHOOL OF NURSING

FOR INSTRUCTORS

1. Nursing Arts Instructor
2. Medical Clinical Instructor
3. Science Instructor (by July 1st, 1958)

1 year university plus experience in teaching & supervision.

also

General Staff Nurses

Good personnel policies.

Apply to: Director of Nursing,

WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO

GENERAL DUTY NURSES

(for all departments)

Gross salary: $235 per mo. if registered in Ontario. $215 per mo. until registration has been established. $20 per mo. bonus for evening & $10 for night duty. Annual increment of $10 per mo. for 3 years.

44-hr. wk., 8 statutory holidays, 21 days vacation.

12 days leave for illness with pay after 1 yr. of employment.

APPLY: DIRECTOR OF NURSING, OSHAWA GENERAL HOSPITAL
OSHAWA, ONTARIO.

PSYCHIATRIC NURSING INSTRUCTRESSES

required by

SASK. DEPT. OF PUBLIC HEALTH

for

SASK. HOSPITAL, NORTH BATTLEFORD

SALARY: $359 PER MONTH.

Requirements: **R.P.N. or Reg. N.** with postgraduate training in teaching & supervision. Consideration will be given to those who have registration in either field of nursing but who do not have the required postgraduate training but are interested in provisional appointments pending formal training for which financial assistance may be provided.

Duties: Appointees will serve as instructresses in a three-year, 600-hr. training program for student psychiatric nurses. They will give lectures, lead seminars, and give practical demonstrations designed to coordinate classroom theory and work on the wards.

APPLICATIONS: FORMS AND FURTHER INFORMATION AVAILABLE AT PUBLIC SERVICE COMMISSION, LEGISLATIVE BLDG. REGINA. APPLICANTS SHOULD REFER TO FILE NO. 5335.

Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

. . . THEY WORK AT

COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $340-$350 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

CANADA'S CHEMICAL VALLEY

SARNIA, ONTARIO

DIRECTOR OF NURSING SERVICES

Required for modern, fully approved (JCAH) 300-bed well equipped hospital. This progressive industrial city of 45,000 is growing; it is a summer resort area located on the shores of Lake Huron and the St. Clair River.

The hospital has approved schools for nurses, laboratory technologists, x-ray technicians, and is approved for intern training.

Qualifications for applicants include registration in Ontario, at least a Bachelor's degree in administration, and successful experience in the field of nursing education as well as in nursing administration.

For more details and literature concerning the position and Sarnia, write to:

Personnel Director,
Sarnia General Hospital, Sarnia, Ontario.

INSTRUCTORS (3)

To teach fundamentals of nursing, maternal, and child health. Student enrollment 83, minimum qualifications — experience in general nursing and certificate in nursing education.

REGISTERED NURSES

Required for general duty staff in modern 300 bed hospital located in resort area in Canada's Chemical Valley. Sarnia, Ontario, is a progressive industrial city located at the junction of the St. Clair River and Lake Huron. Only minutes away are busy shopping areas, spacious sandy beaches, recreational and sports facilities.

The hospital is fully accredited and has approved schools for nurses, x-ray and laboratory technicians, and is approved for intern training.

Apply by Letter to Personnel Director,
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

UNIVERSITY OF ALBERTA HOSPITAL

EDMONTON, ALBERTA.

REQUIRES

GRADUATE NURSES

for general duty.

Good working conditions with a five day week.

FOR FURTHER INFORMATION APPLY:

ASSOCIATE DIRECTOR OF NURSING (SERVICE).

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $250 to $290 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo. 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

THE B. C. CIVIL SERVICE

REQUIRES

DIRECTOR OF NURSING SERVICES
BRITISH COLUMBIA MENTAL HEALTH SERVICES
ESSONDALE, B.C.

Salary: $420-$500 per mo. depending on qualifications & experience. Under general direction of the Medical Superintendent, to administer a large staff of nurses & auxiliary personnel, including general supervision of the School of Psychiatric Nursing, which trains psychiatric nurses & conducts affiliate & postgraduate courses; to advise the Director of Mental Services on related matters. Requires a high degree of initiative & organizing ability. Applicants must be British subjects, eligible for registration with the B.C. Registered Nurses Association, with degree or diploma in administration or equivalent, at least 2 years experience at a senior supervisory level in a large mental hospital.

Apply to the Personnel Officer,
B.C. CIVIL SERVICE COMMISSION, ESSONDALE, BRITISH COLUMBIA
COMPETITION NO. 58:128A.

REGISTERED NURSE

required by Saskatchewan Council for Crippled Children & Adults, Saskatoon, by August 1st or 15th. Starting salary $3600.

Duties include:

1. Supervision of mobile diagnostic & review clinic program.
2. Direction & supervision of Camp Easter Seal for the province during the summer camping season.
3. Supervision of auxiliary community services.
4. Some public speaking.

Apply: stating age, experience & references to Executive Director,
SASKATCHEWAN COUNCIL FOR CRIPPLED CHILDREN & ADULTS,
110 ROSS BLOCK, SASKATOON.

GENERAL STAFF NURSES

2 positions in the O.R. available in September
also positions in other Departments
200-bed General Hospital
Pleasant City of 33,000 - 3 Colleges
Good salary & Personnel Policies
Additional salary for postgraduate course
in operating room or obstetrics

For further information apply to:
THE DIRECTOR OF NURSES, GUELPH GENERAL HOSPITAL, GUELPH, ONT.

THE ROOSEVELT HOSPITAL
APPLICATION FOR APPOINTMENT
NURSING SERVICE DEPARTMENT

NAME .....

ADDRESS .....

.....

BIRTHDATE ..... MARITAL STATUS .....

WHERE REGISTERED .....

CLINICAL SERVICE DESIRED .....

POSITION SOUGHT .....

DATE AVAILABLE .....

EDUCATIONAL BACKGROUND

SCHOOL OF NURSING	ADDRESS	DATE OF DIPLOMA OR DEGREE

EXPERIENCE (LIST MOST RECENT POSITION FIRST)

POSITION	HOSPITAL	LOCATION	DATE

TRANSPORTATION PAID UPON APPOINTMENT TO STAFF.

SEND TO: DIRECTOR, NURSING SERVICE
THE ROOSEVELT HOSPITAL
428 WEST, 59TH STREET
NEW YORK 19, NEW YORK.

LA SOCIÉTÉ DE LA CROIX-ROUGE CANADIENNE

offre aux infirmières des positions en service général ou administratif de Terreneuve à la Colombie Britannique.

dans

les hôpitaux
l'hygiène publique
le service des transfusions

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en

ONTARIO
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OFFRE D'EMPLOI LIMITEE

en

SASKATCHEWAN
MANITOBA
QUÉBEC
TERRENEUVE

SALAIRES:
selon l'expérience et la préparation.

BOURSES D'ETUDES OFFERTES

Dépenses de voyages défrayées dans certaines circonstances.

La directrice nationale du Service du Nursing,

LA SOCIÉTÉ
DE LA CROIX-ROUGE CANADIENNE
95 EST, RUE WELLESLEY,
TORONTO 5, ONTARIO

SOUTH PEEL HOSPITAL

COOKSVILLE, ONTARIO
(12 miles west of Toronto)

Hospital opened May 15, 1958.

STAFF REQUIRED:

General Duty — for all services

Generous benefits — 40-hr. week

For further particulars apply:

DIRECTOR OF NURSING,
SOUTH PEEL HOSPITAL,
COOKSVILLE, ONTARIO.

DIRECTOR OF NURSING

For 227-bed hospital in Cornwall, Ontario

Position requires graduate nurse with experience managing nursing staff, maintaining high standards of patient care, etc.

Further details on request.

Reply with details to:

CHAIRMAN,
BOARD OF GOVERNORS.
CORNWALL GENERAL HOSPITAL

ST. MARY'S HOSPITAL MONTREAL

OPPORTUNITY FOR NURSES AT ST. MARY'S

we invite you

TO SHARE AND INCREASE YOUR EXPERIENCE AND
SKILL IN OUR MODERN, WELL ORGANIZED
300 BED GENERAL HOSPITAL

EXCELLENT OPPORTUNITIES OFFERED FOR
GRADUATES AND NURSING ASSISTANTS
IN
MEDICINE, SURGERY, OBSTETRICS, PAEDIATRICS
AND OPERATING ROOM
CONSIDERABLE SCOPE FOR ADVANCEMENT
ATTRACTIVE PERSONNEL POLICIES
SALARIES IN LINE WITH SCALE RECOMMENDED BY
PROVINCIAL NURSES ASSOCIATION

FOR FURTHER INFORMATION WRITE TO

DIRECTOR OF NURSING SERVICE
ST. MARY'S HOSPITAL, 3830 LACOMBE AVE., MONTREAL

OPERATING ROOM SUPERVISOR
for
SAINT JOHN GENERAL HOSPITAL
(400-BED)

SCHOOL OF NURSING — 150 STUDENTS

QUALIFICATIONS: POSTGRADUATE CERTIFICATION IN OPERATING ROOM TECHNIQUE & MANAGEMENT WITH EXPERIENCE.

Apply to: Director of Nursing,

SAINT JOHN GENERAL HOSPITAL, SAINT JOHN, NEW BRUNSWICK

REGINA GENERAL HOSPITAL
REQUIRES THE FOLLOWING NURSE PERSONNEL:

A. — ASSOCIATE DIRECTOR NURSING SERVICE.
— ASSISTANT DIRECTOR NURSING SERVICE.
— HEAD NURSE — NEWBORN NURSERIES.

B. — ASSISTANT DIRECTOR — NURSING EDUCATION.
— CLINICAL INSTRUCTOR — OPERATING ROOM.

APPLY TO: DIRECTOR OF NURSING, REGINA GENERAL HOSPITAL, REGINA, SASKATCHEWAN.

LADY MINTO HOSPITAL, COCHRANE, ONTARIO
requires:

1. **HEAD NURSES** FOR SURGERY & PEDIATRICS. Gross salary $292 per mo.
2. **GENERAL DUTY NURSES,** all departments. Gross salary $267 per mo. Annual increments based on merit & tenure. Above salaries apply to nurses currently registered in Ontario.

For further information, Apply to Superintendent.

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(2) Regional Superintendent, c/o Charles Camsell Indian Hospital, Edmonton, Alberta.

(3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.

(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

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